DOCTOR OF PHILOSOPHY

From Origins to Output

Understanding Routinely Collected Social Care Data Processes and Management with Consideration to Health and Social Care Integration

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Understanding Routinely Collected Social Care Data Processes and Management with Consideration to Health and Social Care Integration.

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DEGREE OF DOCTOR OF PHILOSOPHY

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Table of Contents

1. LIST OF TABLES

2. LIST OF FIGURES

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4. DECLARATION

Candidate Declaration

I, Anne Canny, hereby certify that I am the author of the present thesis; that, unless otherwise stated, all references stated have been consulted by me; that the work of which the thesis is a record has been conducted by me; and that the thesis has not been submitted in any previous applications for a higher degree.

Candidate Signature: Date: 17 December 2019

5. DEDICATION

For Mum 1927-2017

6. ABBREVIATIONS

ADL - Activities of Daily Living

AHP - Allied Health Professionals

ANT - Actor Network Theory

AR - Action Research

ASD - Scottish Analytical Services Division

BMJ - British Medical Journal

CCGs - Clinical Commissioning Groups

CHCA - Continuing Health Care Assessment

CHI - Community Health Index Number

CP - Community Planning

CPD - Continual Professional Development

CPN - Community Psychiatric Nurse

CPR - Cardiopulmonary Resuscitation

CT - Computerised Tomography

DH - Department of Health

DNA - Deoxyribonucleic Acid

DST - Decision Support Tool

DTM - Demographic Transition Model

EBM - Evidence Based Medicine

EMI - Elderly Mentally Infirm

EPR - Electronic Patient Record

FMRI - Functional Magnetic Resonance Imaging

FTA - Face Threatening Acts

GBD - Global Burden of Disease

GDP - Gross Domestic Product

GDPR - General Data Protection Regulations

GP - General Practitioner

HEAT - Hospital Efficiency and Access Targets

H&SC - Health and Social Care

H&SCI- Health and Social Care Integration

HSCIIP- Health and Social Care Integration and Intelligence Project

HPV - Human papillomavirus

IA - Integrating Authority

ICD - International Statistical Classification of Diseases

ICF - International Classification of Functioning, Disability and Health

IDS - Immediate Discharge Service

IRAS - Integrated Research Approval System

ISD - Information Services Division

IT - Information Technology

IV - Intravenous

LDP - Local Delivery Plan

MDT - Multidisciplinary Team

MFE - Medicine for the Elderly

MRI - Magnetic Resonance Imaging

NHS - National Health System

NPfIT - National Programme for IT

NVQ - National Vocational Qualification

OFA	-	Outcomes Focused Assessment
OOH	-	Out of Hours
OPD	-	Organisational and Professional Development
OT	-	Occupational Therapist
PRTL	-	Post Registration Training and Learning
PDD	-	Planned Date of Discharge
QOF	-	Quality and Outcomes Framework
RCT	-	Randomised Controlled Trial
SCICE	-	Social Care Institute for Care Excellence
SES	-	Socio-economic Status
SOA	-	Single Outcome Assessment
SSA	-	Single Shared Assessment
SSSC	-	Scottish Social Services Council
SVQ	-	Scottish Vocational Qualification
SW	-	Social Work
UK	-	United Kingdom
UN	-	United Nations
URN	-	Unique Reference Number
USA	-	United States of America
WHO	-	World Health Organisation

7. SUMMARY

Background. This thesis explores routine social care data collection and management processes resulting from the Scottish Government's strategic vision for 2020 and the formal implementation of health and social care integration. Key to this strategy is the initiative to use routinely collected social care data to evaluate services and also to combine these data with health care information in order to inform service access, use comparison and future planning. In stark contrast to healthcare information, social care data has not been formally evaluated to date. This thesis addresses the disparity in knowledge and understanding between the two organisations. The overall aims were to build a comprehensive understanding of how social care data materialises; how data are collected, coded, shared and managed.

Method. A multiple-site ethnography incorporating semi-structured interviews, non-participation observation and supporting documentary analysis were used to capture routine practices of social care staff holistically and contextually from the perspective of the people themselves. Data were collected from 29 participants over an 18 month period then transcribed verbatim and uploaded to Nvivo© 11 software programme for coding, synthesising and data management. Analysis proceeded interpretively and in parallel with ongoing interviews and observations and was informed by drawing from the theoretical framework of actor-network theory and the sociology of the professions.

Findings. Field sites revealed a broad but common framework of legislated mandates which authorised staff to gather information, although local variations in forms and procedures were noted across regions. Analysis revealed 4 overarching themes of influence (Data processes, IT Systems, Organisational Systems, Inter/intra-professional relations). From these, some overlapping concepts were recognised as having a significant bearing on day to day operations and practices: Leadership/Management, Philosophies and Standardisation. This intricate blend of inter-related issues highlights the messiness and multi-dimensional measures at force in complex organisations such as health and social care. Conducted on the cusp of health and social care integration formally going live during 2016, this thesis provides a new body of knowledge to data processes and is one of the first of its kind to evaluate social care data in the UK – from origins to output. In consideration of findings from this study, there are consequences with regard to policies, procedures, education and training that could serve as further stimuli to aid direction to absolute integration.

1. CHAPTER 1. INTRODUCTION

1.2. Background to the Decision to Integrate Health and Social Care

Health and Social Care services in the UK are facing significant challenges, making current provisions difficult to sustain in their present form [1-7]. This is largely due to an ageing population, an increased prevalence in multiple long-term health conditions, driving a greater need for on-going health and social care services [4, 7-10]. Managing these challenges amidst economic uncertainty, budgetary constraints and finite resources calls for innovative policy reform. In response, the UK government has signalled that health and social care integration is a national priority [11].

1.3. Legislative Framework for Health and Social Care Integration

To officially address and realise change in support of health and social care integration, UK Government ministers delivered their reform mandate to NHS England during 2012. The directive was presented to parliament in accordance with Section 13A(1) of the National Health Service Act 2006 to which NHS England and local authorities are legally bound to comply [12, 13]. Scotland, Wales and Northern Ireland have held devolved affairs since 1999, therefore their health and social care reform directives were developed independently [14]. Scotland (where the work of this thesis was conducted) introduced the Public Bodies (Joint Working) Scotland Act, 2014 which provided the legal framework for health and social care integration, and this bill received royal assent on 1 April 2014 [15].

1.4. Why Integrate Health and Social Care?

The model of episodic, acute healthcare upon which many hospital services are still based is appropriate for normally healthy people who become ill. It is however, less suitable for people with chronic diseases, and even less suitable for people with multiple conditions. Many health conditions, particularly those of a complex or long-term chronic nature, may be better managed out-with the traditional hospital setting. There is therefore a move towards delivering care through a multidisciplinary team approach rather than under specialist consultant control [16, 17]. A fundamental driver to the integration of health and social care is the significant change which shifts the balance of care away from acute provisions to that of care delivery within a person's own home or other

community setting appropriate to their need [18]. This means people can avoid unnecessary admission to acute hospitals due to improved continuity of care in a person's own home from a pre-emptive rather than reactive perspective. Well-being can be maximised whilst the onset of future deterioration or crises can be monitored and minimised [6]. Alternatively, if admission is unavoidable, discharge is co-ordinated via multi-disciplinary teams in a timely and appropriate manner so as to minimise the length of hospital stay [6].

Joining National Health Services (NHS) and local authority social care under one partnership agreement is considered central by the UK Government to help streamline services and deliver excellence in co-ordinated health and social care efficiently and cost effectively [12, 13]. Traditionally, NHS and social care services operated separately which meant a person's care was often delivered by a variety of health and social care professionals in a fragmented manner [17]. Duplication and gaps in care delivery were common, generally caused by a lack of communication and inflexibility in work flow patterns. Co-ordination was hampered due to an inability to work across diverse health and social care sector professions, systems and boundaries [17-21]. These factors are discussed further in subsequent chapters.

Joined-up services place an emphasis on the presence of a co-ordinated 'whole system' approach [22 p.2]. This aims to improve a patient's care journey through the provision of the right care at the right time and in the right place. Integrated care pathways therefore aim to reduce service fragmentation, alleviate pressures on acute services and manage best use of available resources in a person-centred manner to meet the growing demand [22].

1.5. Shift in Responsibility

The UK, Western Europe and North America's health care systems progressed via the adoption of the medical model, a prescriptive illness and cure approach. The UK NHS evolved to a model where single-organ specialities based in hospitals dominated, both in terms of attracting the bulk of funding for healthcare, but also in terms of how health services were organised. The NHS has, since its inception, been funded by general taxation and national insurance contributions, but free at the point of access [16, 19]. Conversely and historically, social care services operated under local authority control

and because of their past (which will be discussed in more detail later) usually delivered means-tested services with eligibility criteria [20]. Social care services were viewed as the 'poor relation' mostly due to less generous funding than health care where they also retained less power and were subsequently dominated by the NHS [21 p.12] .

A much broader remit now exists in the 21st Century where health and social care are driven more from a community-based and holistic perspective. Services are being directed largely through general practitioner (GP) practices and social work departments rather than from the boundaries of acute hospital settings and clinical directives [7]. Greater responsibility for health and social care is now delegated to multidisciplinary teams, providing a wide range of services across social work departments under local partnership agreements. In Scotland, joint community health and social care boards now control much more funding and therefore hold more power to shape and commission services. If these cross-sectoral teams are to work effectively, they will require access to high-quality data that reflect activity across all domains. Such data require a full understanding of provenance if they are to be used for service evaluation and future planning [22].

1.6. Evaluation of Services

Central to health and social care integration is the initiative to use routinely collected social care data to evaluate services and also to combine these data with health care information in order to inform service planning, delivery, quality and comparison [23]. These data have the ability to provide an individual, regional and national profile of service access and use which can both shape pathways of care and support public health programmes. Findings also have the potential to suggest new models of care whilst at the same time help to identify and decommission models no longer fit for purpose [7, 23].

The UK and Scottish Governments recognise that in order to obtain and maintain a robust evidence base that supports planning, delivery and comparison of its services, effective information systems are necessary [23, 24]. 'Let the data guide you' is the new mantra in relation to service development and evaluation [25 p.1]. However, organisations need to have confidence in accuracy, consistency and integrity of information collected since results from any analysis are only as reliable as the quality and stability of

information provided in the first instance [23]. Letting the data guide you is appropriate only if analysts and strategists have a meaningful understanding of what these data mean in order to avoid findings from being misleading. As the Scottish Government's Health and Social Care Partnership reiterated; 'Whatever data sources are used, it is important to be clear about where the data came from and to be aware of the strengths and limitations of those data' [22 p.3].

1.7. The Gap between Health and Social Care Data

Analysing large amounts of data does not necessarily translate into gaining knowledge or understanding unless data are fully understood. To this end, healthcare data have been extensively evaluated over the years and so strengths and weaknesses of these data are already known and subsequent lessons have been learned [26-31]. For example, a report published by Imperial College London identified wide variations in how clinicians coded health conditions making analysis difficult when comparing between areas in a region/country or between populations over time [31]. Additionally, an emphasis was placed upon a lack of completeness in data between GP practices alongside a lack of standardisation, preventing effective and meaningful analysis. Programmes such as the Quality and Outcomes Framework (QOF) and the widespread use of electronic GP records have led to improvements in the quality of data collected in primary care, albeit through annual financial award incentives [31].

Other notable commentaries stress organisational, social and cultural factors which impact on the processes and management of health care data [32, 33]. Most fundamental is the recognition of the human element involved in shaping information to 'recontextualize knowledge' as Greenhalgh and colleagues report [32 p.767]. Moreover, Takian and colleagues examined the difficulties faced during the redistribution of tasks to enable the transfer from paper-based documents to electronic patient records [34]. The additional time required to train clinicians, nursing and administration staff in an already rapidly changing and demanding environments, was exacerbated by unprecedented budget cuts and major structural change which led to disengagement from some sectors [34-36].

Whilst there is much in the literature reporting health care data quality and consistency as well as contextual influences, there is a dearth of similar work when searching for social care data critiques. Social care information has not been formally evaluated to date or been used for analyses in any great depth in Scotland and thus our understanding of this information is limited. There is a great need to gain an in-depth awareness of strengths and weaknesses of these before they can be applied to any analysis [22]. For instance, how data are created, used and shared and also how data flows through processes and systems are all potentially important. It is crucial to have an insight into what these data mean and what factors influence decision-making when creating and managing such information.

This lack of knowledge is echoed by the Kings Fund who reported under-developed social care data in contrast to healthcare information, and consequently call for further work in this area as a matter of urgency [21]. Similarly, Sharland notes a long standing under-investment in social work research and infrastructure, especially noticeable in comparison with health [37]. Additionally, Rigby and colleagues mirror the call for similar action in their report [38]. Information Services Division (ISD) health and social care partnership emphasise gaps in social care data particularly in relation to patient/client risk factors [22]. Other reports point towards challenges faced around social care data collection, documentation, and workflows alongside different cultural and professional values [39, 40]. It is therefore unsurprising to learn that social care service outcomes have proved notoriously difficult to evidence in the past [41].

1.8. Evidencing Outcomes

If evidencing social care outcomes are difficult in general, then evidencing services for some groups are particularly challenging, especially for people with complex needs, older people or those living with frailty [41]. For example, the Social Care Institute for Care Excellence (SCICE) encourages social work departments to measure from an outcomes-focused perspective to assess the quality of its service provision [41]. At this point it may be pertinent to clarify what is meant by outcomes-focused services. During the assessment process, a client identifies their priorities, goals and aspirations and these are incorporated into their care package and are thought to reflect good outcomes when achieved [42]. Good outcomes are positively associated with good quality services therefore one may assume a person has high quality of care when outcomes-focused

measures are realised. However, the report warns that these indicators may fail to capture the true complexity of an individual's situation. This is reaffirmed by Reed who suggests good outcomes, although interrelated, can be independent of good quality care [43]. For example, some people may feel content and fulfilled but receive poor care. Alternatively, others may feel their goals and aspirations are unachievable despite being in receipt of high quality care [43].

No matter how difficult evidencing outcomes may be, evidence is essential, especially in the face of increasing demand for services amidst severe budget constraints. To coin the words of Archibald Cochrane:

> *'because resources would always be limited, they should be used to provide equitably those forms of health care which had been shown in properly designed evaluations to be effective'* [44 p.156, 45].

Cochrane's statement was in response to findings where there was 'inefficient use of effective therapies' and 'considerable use of ineffective ones' [45 p.67]. It therefore seems prudent to revisit the fundamental building blocks of social care information creation, processes and management in order to gain an understanding of how data can be used to achieve these purposes.

1.9. An Ethnographic Approach

To address the absence of evaluation, this thesis explores social care data in Scotland from its origins and studies how social care data are created. This includes discovering how data are collected, how data are coded, how data flows through systems and organisations, and how this information is used and managed within and across agencies. Particular consideration is also given to understanding organisational and professional dynamics during these processes. Answering these questions will develop a better understanding of social care data and bring knowledge in line with what is known from health sector information.

This study employs ethnographic methods to understand entire procedures enacted during data collection processes and management. This includes obtaining views and experiences from a wide range of health and social care staff including executives, managers, administrators and front-line staff. Ethnography, an iterative-inductive approach, accepts the principle that behaviour of individuals and groups must be understood within their 'natural' rather than artificial setting [46 p.4]. This involves studying events as they happen, capturing real-time phenomena rather than relying on retrospective reports or accounts [47]. For example, there can often be a difference between what people say they do and what they actually do [48]. Ethnography provides in the moment insights of how people and organisations function from a bottom-up line of enquiry capable of distinguishing between what Whitehead terms the 'real' from the 'ideal' [48 p.15]. Conducting research in this manner can uncover implicit or hidden associations in organisations [47].

Ethnography is being used more often in health and social research [49-51]. Recent examples include understanding and self-management of diabetes and congestive heart failure; [52, 53] in examining prescription practices; [54] and in exploring the impact of the written and electronic patient records [32, 55]. Studies from a social care perspective include observing interactions between social workers and homeless people; [56] understanding growing old in contemporary Britain; [57] and in looking into learned professional discourse of child protection services [58].

This study aims to provide a deeper understanding of what social care information actually represents. The findings will shed light on its values and limitations which in turn have the potential to influence future analysis of service demand, planning, delivery and quality in this rapidly changing landscape. The study also offers the possibility to help drive programmes that support strategic planning and decision-making to benefit the needs of health and social care integration.

In view of our ageing population and an increased prevalence in multi-morbid health conditions, this thesis examines social care data collection processes through the lens of older people and social care professionals/managers. The rationale behind this approach lies with the knowledge that age carries an increased risk of ill-health where many will require support from primary, secondary and tertiary care services [59-61]. This is often

coupled alongside the need for social care involvement either by a variety of short-term measures or a long-term package of care [62, 63].

1.10. Overall Aims and Objectives

The overall aims of this thesis are to build a comprehensive understanding of social care data creation, processes and management. In order to achieve these aims three main objectives are presented.

1. To explore how routine social care data are collected in the first instance and this includes investigating how information is gathered at the outset during client/patient assessment in the community and also in acute settings.

2. To examine how social workers record and code this information. Particular consideration is given to finding out how social workers make judgements during assessment and considers what factors influence decision-making processes.

3. To find out how data flows through procedures and systems and also how data are used and shared within social care and between different agencies.

To meet these objectives the study draws from a multiple-site study at three different local authorities in Scotland which will be informed by actor network theory (ANT) and the sociology of the professions theoretical frameworks.

1.11. Summary

This chapter has presented the rationale and requirement for the UK government's decision to integrate health and social care services. The legislative framework to formally enable strategic change was described alongside explanations of motives and drivers. The chapter acknowledges medical advances and increased treatment options that can be delivered by multidisciplinary teams of health and social care professionals rather than from the confines of traditional but disparate systems and settings. People are therefore able to successfully manage health conditions from a holistic perspective in their own home or normal place of residence. The chapter later identified the necessity for robust datasets that accurately captures and reflects service activity and quality to

enable analysis of service provision, planning and comparison. Healthcare data has been comprehensively evaluated contrary to social care information therefore, this study aims to reduce the incongruence to bring knowledge and understanding of social care data in line with that of health care information. The chapter closes with support for an ethnographic study as a fitting approach to achieve the aims and objectives from the views and experiences of a wide range of social care professionals.

2. CHAPTER 2. HEALTH, SOCIAL CARE AND AGEING IN CONTEXT

2.1. Introduction

Chapter 1 presented the foundation for this thesis and emphasised why it is necessary to evaluate social care information processes in Scotland. This chapter offers a brief historical account of NHS and social care to encapsulate their evolution as separate entities over time and space, thus giving an appreciation of what issues health and social care integration holds for each organisation. Both have a distinct past retaining different philosophies, values and practices. The chapter also offers an explanation of how and why populations have evolved over time as this is closely connected to current challenges and opportunities within contemporary health and social care provision [64]. Concepts of population structures, life expectancy, ageing and multi-morbidity are discussed to shed light on key causes for people living longer, prompting the need for a co-ordinated whole system approach to care. The final section in the chapter considers information technology and the role computing systems play, against a background of rapid developments in electronic storage, processing, analyses and data management. Issues that influence social care data collection and management practices will be highlighted.

2.2. Birth of the NHS

The Social Insurance and Allied Services report also known as the Beveridge Report was unveiled by Sir William Beveridge on 1st December, 1942 [65]. Beveridge, an economist of high regard envisaged post war Britain featuring a welfare state including a national health service. Funding for the venture was obtained directly from general taxation and national insurance contributions. The NHS was subsequently born on 5th July 1948 under the leadership of then Health Secretary Aneurin Bevan [66, 67]. Since its inception, the ethos was and still remains good healthcare for all irrespective of wealth. Its core principles steered development with the focus directed towards;

- The needs of everyone
- Free at the point of access

- Based on clinical need and not ability to pay

For the very first time in UK history, the birth of the NHS introduced free access to a family doctor, prescription drugs, hospital services, spectacles and dentures for the entire population. Hospitals, medical staff, GPs (General Practitioners) and prescription medications were brought under the same umbrella configuration.

2.2.1. NHS a Brief History

The NHS has grown dramatically over its 71-year history presenting some remarkable medical achievements impacting public health. From the link between smoking and lung cancer in 1954 to the introduction of extensive vaccination programmes in 1958, followed by wide availability of oral contraceptives in 1961. Firsts in hip replacements, heart and kidney transplants were performed during 1960's. Then later in-vitro fertilisation, key-hole surgery and sophisticated imaging using CT and MRI scans developed during 1970's and 1980's. More recently, initiatives in preventative health care including the HPV vaccination programme, enclosed public places smoking ban and Scotland's Hepatitis C Action Plan continue to improve the health and wellbeing of the country [66, 67]. It is perhaps no surprise that NHS is revered by the public as a national treasure. Compliments are not beyond the scope of politicians either where even former Prime Minister David Cameron was noted to state 'the most precious institution we have' [68 p.1].

2.2.2. The Contemporary NHS

The UK NHS Constitution was published during 2011 in consultation with NHS staff, service users and the wider public to legally cement seven core principles enhancing Aneurin Bevan's original ethos [69]. Presently, NHS UK employs over 1.7 million staff making the organisation the fifth largest employer in the world [70]. Of the four countries making up the UK, (England, Scotland, Wales, Northern Ireland) each hold full legislative powers over respective healthcare services [71]. The NHS is regarded as the world's largest publicly funded health service reflecting an expenditure of 9.75% Gross Domestic Product (GDP) [66, 72]. During 2016 more than £111bn; £11.2bn; £6.4bn and £3.9bn in public capital was attributed across NHS England, Scotland, Wales and Northern Ireland respectively [73].

The Commonwealth Fund acknowledged that in comparison with healthcare systems of ten other countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland and the USA) the NHS was the most impressive overall across quality, access and efficiency as shown in Figure 1. [74]. This is in stark contrast to what Warner and O'Sullivan reported during same year citing 'The NHS faces a combined care and cash crisis that threatens to debilitate the wider public sector and economy' [75 p.5]. Thus, although the NHS has much to be proud of, it is not without significant challenges [76].

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Figure 1. Commonwealth Fund comparison of health services from 11 countries, sourced from: http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror [74].

2.2.3. NHS Scotland

Holding devolved affairs since 1999, the responsibility for NHS Scotland lies with the Scottish Government legislated by parliament in Holyrood, Edinburgh. The Government determines fiscal expenditure on healthcare which currently stands at almost £12 billion per year [77]. NHS Scotland is made up of 14 regional health boards who are accountable to the Scottish Cabinet Secretary for Health and Wellbeing [78]. Health boards are supported by seven other specialty health boards and one Public Health body, incorporating dedicated services alongside Healthcare Improvement Scotland who

monitor aims, objectives and performance [79, 80] . Primary care comprises 968 GP practices [80]. NHS Scotland is the second largest NHS authority in the UK employing over 160,000 staff to support the Scottish population of almost 5 million citizens (Figure 2).

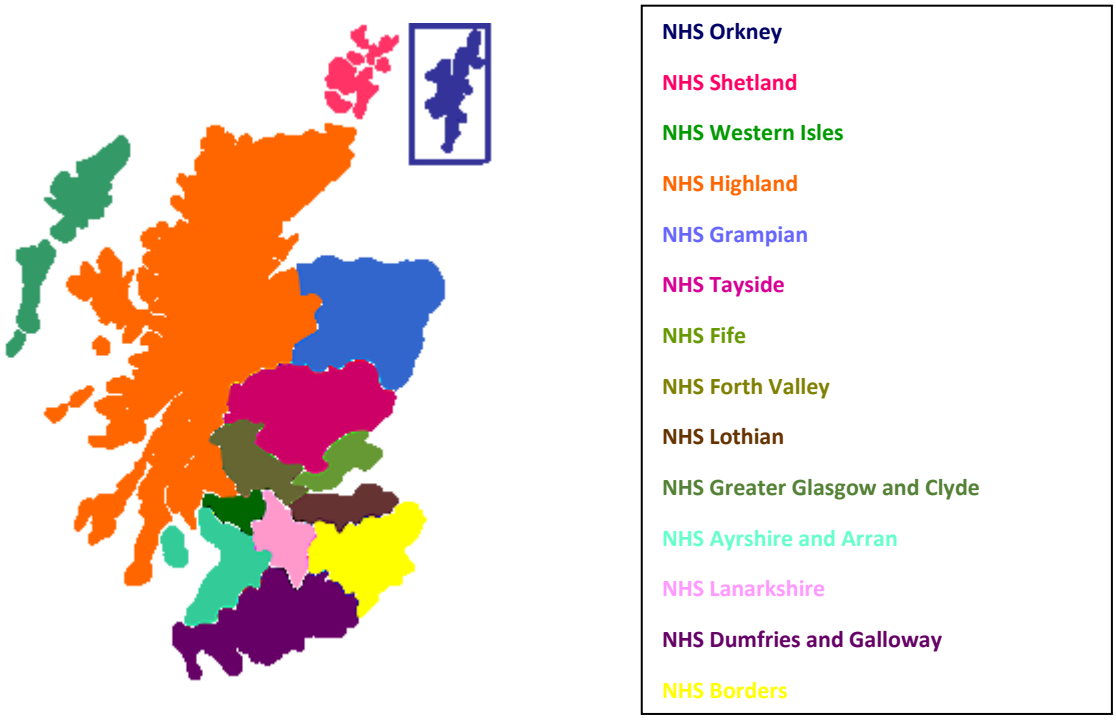

Figure 2. 14 regional health boards in Scotland (78) http://www.scot.nhs.uk//organisations/.

2.3. Social Care

The UK Poor Law was formally introduced in 1601 to ensure the needy of society were looked after. People in hardship received payments for food, clothing, shelter and education. Alms-houses offered charitable housing to mainly older people who could no longer work or earn enough to pay rent [81]. Costs attached to the Poor Law were met by local levies paid by middle and upper class members of parishes alongside voluntary sectors. Provisions were regulated via a means-tested basis and eligibility criteria. By the time the UK entered the Victorian era, many viewed the needy as lazy and idle and their situation regarded as a result of their own making [81]. Subsequent Law amendments during 1834, termed the "New Poor Law" introduced central government control rather than the existing, apparently unorganised, parochial jurisdiction. The amendment followed from unrest regarding the rising burden of cost for care by rate-payers. Funds were injected into networks and buildings which were deliberately designed to be less than desirable places of work for the poor, commonly known as workhouses [81].

Conditions that ensued were harsh and often cruel leading to many fearing and avoiding these punitive regimes [82]. Rapid increases in street paupers and greater social deprivation followed [83].

2.3.1. Social Security and Allied Services

The Poor Law continued to be exposed to complex layers of urban, economic, social and political change which hampered its original purpose and effectiveness until the Act gradually fell into decline [84]. The Social Insurance and Allied Services Act, was subsequently introduced to British policy following the end of World War 11 in 1945 [85]. The report promised an insurance-based welfare that offered security to all 'from the cradle to the grave' [86 p.30) [65]. Beveridge's aims were to abolish the 'five giants on the road of reconstruction; want, disease, ignorance, squalor and idleness' [65 p.67]. People from all classes were guaranteed subsistence to protect from hardship whether through unemployment, accident, disability, disease or old age. William Beveridge referred to the term as Social Security, originally coined by the United States Government and designed to give freedom from want by maintaining incomes [87].

2.3.2. Contemporary Social Care

The UK currently operates a mostly publicly funded social care system to look after older people unable to meet their own care needs. Different services are available for different needs and these comprise; care home (residential/nursing/specialist mental health), sheltered housing and care provided within an individual's own home. These services are provided by local authorities or privately contracted/voluntary sectors. Some forms of care may involve help with personal hygiene and activities of daily living (ADL), more commonly known as personal care. Delivery of meals, domestic home-care services, luncheon clubs and day centres are other forms of additional services [88, 89]. A referral to social services for help and support can take many forms; either in person, by another family member or carer, via a GP or other healthcare professional. A social worker then carries out a comprehensive assessment of need [90]. A care plan is developed based on individual requirement to maximise wellbeing which is reviewed at assigned intervals until a client's case is closed. This is known as Single Outcome Assessment (SOA), Outcomes Focused Assessment (OFA) and in some instances Single Shared Assessment (SSA). An emphasis is placed upon sustainability; enabling a

patient/client to live independently with dignity, and to remain in their own home or other appropriate homely setting [91]. Scotland and the other three countries comprising the UK differ in their social care policy as shown below.

2.3.3. Social Care in Context of Scotland

Unlike health care, social care provision in all four countries of the UK is means-tested with a strict eligibility criteria, reflecting its origins from the Poor Law [92]. Rules regarding payment are set out by the Westminster government therefore, currently if an individual has income or wealth they are required to contribute to their care [93, 94]. Care costs vary within and across countries as one might expect due to variations in regional overheads[1]. It should be pointed out that some care provisions are non-chargeable such as short-term services following hospital admission, or recovering from injury, surgery or illness, sometimes also termed reablement or enablement [95, 96]. Reablement is provided by local authorities usually in partnership with NHS and normally lasts for 6 weeks, but this can be extended.

Social care in Scotland follows a similar structure to other UK regions however, under devolved powers the Scottish government extends free personal care to people over 65 years [97]. Thus, everyone who has been assessed by social services and confirmed in need are currently provided with home care irrespective of wealth across all 32 local authorities (Figure 3). Residential care home costs are also covered by government benefit provided individuals meet set criteria[2] [97, 98]. Local authorities provide other services but these are means-tested and costs levied for those who are in a position to pay. These services and their costs vary across local authorities including laundry, housework, shopping, delivery of meals, day care centres, community alarms and other electronic devices or equipment.

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[1] Local authorities in England are not required to help with costs if individual assets are above £23,250 (including property). Deferred payments can be arranged against the value of owned property which is then redeemed from a client's estate after death. Recently, the government proposed a change of threshold from £23,250 to £118,000 with a cap of £72,000 personal contribution, however, this has been postponed to 2020. [91]

[2] There are lower and upper levels of permitted capital in order to qualify for residential or nursing care home costs. Upper and lower levels presently stand at £26,250 and £16,250 respectively. If an individual has less than the lower level, care home costs are covered in total by the state. If a person has more than the lower level, but less than the upper lever, some costs are covered by applying an algorithm. People with more than the upper level have to meet their own care home costs in full. Self-funding individuals are currently awarded their personal care allowance of £171 and £249 per week towards residential and nursing home costs respectively. [95]

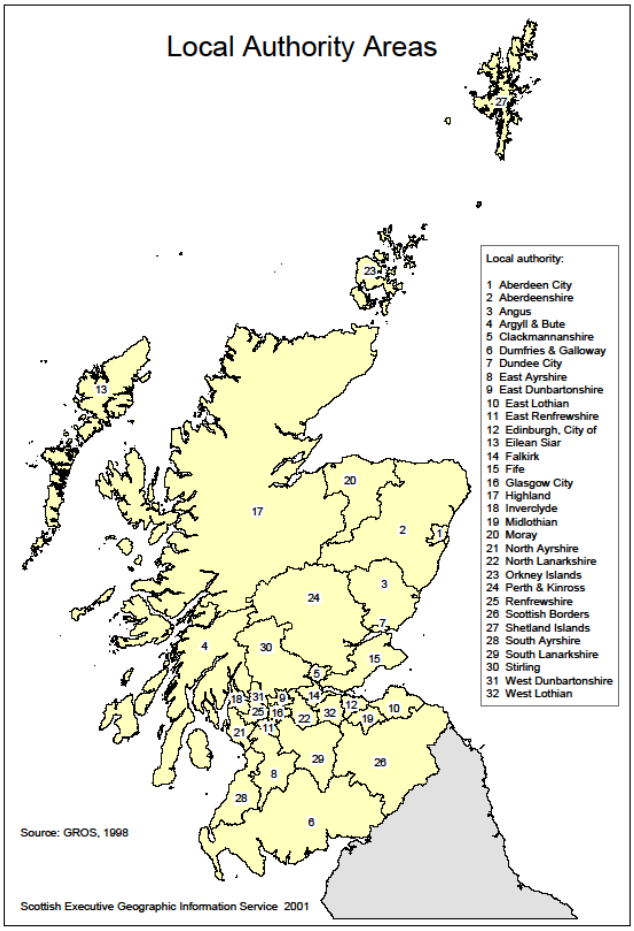


Figure 3. Local authority boundaries of Scotland. Sourced from: http://www.gov.scot/Resource/Doc/933/0009386.pdf (99)

2.4. What is Health and Social Care Integration?

The literature contains a variety of definitions to describe health and social care integration and the definition continues to evolve [100, 101]. Equally, a number of different frameworks have been cited which consider levels (micro, meso, macro) and also different forms (horizontal, vertical, sectoral, people-centred, whole-system) [101, 102]. In essence, integrated care is a strategy to streamline services within the health and social care landscape and to maximise experiences and outcomes for clients/patients, their carers and families. The approach is particularly suited to those with complex or long-term care needs, or who do not fit neatly into disease specific pathways, yet the strategy can also be applied to wider health and wellbeing. Therefore, for the purpose of this thesis, the UK Government description will be used. The following is a representation of what is meant by health and social care integration:

> *'Care that is person-centred and coordinated across care settings. Integration can be within different healthcare settings (e.g. primary and secondary) or between health and social care services. Better integration between health and social care has been put forward as a way to reduce costs, relieve pressure on services and improve user outcomes and experiences.'* [103 p.1].

These ambitious objectives offer the opportunity to make NHS and social care more efficient and seamless, putting patient care first in conjunction with being more cost-effective [12, 104]. Integration, joined up services or partnership working as they are also known are intended to improve patient outcomes by meeting physical, psychological and social care needs at a local level (biopsychosocial), built around individuals, their carers and family.

Government ministers subsequently delivered their reform mandate to NHS England during 2012 (presented to parliament in accordance with Section 13A(1) of the National Health Service Act 2006) to which NHS England and local authorities are duty bound to comply [12, 13]. An additional injection of almost £5 billion has been committed to enable local authorities and NHS health boards in England to integrate [105]. Scotland, Wales and Northern Ireland's health and social care services are devolved affairs therefore their reform directives were developed independently [14].

2.4.1. Scotland Perspective

The Scottish Government embraces a strategic vision for 2020 which aims to improve the lives of its citizens [106]. The Public Bodies (Joint Working) Scotland Act, 2014 provided the legal framework for health and social care integration and received royal assent on 1 April 2014 [15]. NHS Scotland and 32 local councils are now mutually responsible for ensuring that people who require health and social care services receive timely, holistic and co-ordinated support during all stages of their care journey.

Health and social care integration went live in Scotland on 1st April 2016 and provides the impetus to improve quality and consistency of person-centred care to people, whilst safeguarding and upholding economic viability [106]. Central to integration is the

significant change which shifts the balance of care away from acute provisions to that of care delivery within a person's own home or other community setting appropriate to their need. Joined-up services of this nature places an emphasis on the presence of a co-ordinated 'whole system' response in order to improve patient pathways and help reduce pressures on acute services [106 p.2].

There is wide scale support for Scotland's 2020 vision and great progress has been made to integrate services with most integrating authorities (IA) meeting minimum statutory requirements during 2015 [107]. A more recent report described the emergence of new care models however, there is a lack of evidence regarding their success [6]. The report also suggested ways the Scottish government could help expedite new models through stronger leadership and a clearer framework to guide IA's, suggesting the process is not moving as fast as it needs to meet increased demand [6]. Other reports challenge integration in terms of delays and quality of diagnoses due to a lack of specialist referral and incentivised schemes to reduce these referrals to hospitals [108].

2.5. Health and Social Care Standards

Health and Social Care Standards were introduced as separate entities by the Scottish Government under the Regulation of Care (Scotland) Act 2001 [109]. However, due to the rapidly shifting landscape of health and social care delivery, care standards were reviewed to reflect current policy. A new single set of Health and Social Care Standards were developed and came into effect in April 2018. These new Standards are based on human rights and wellbeing across all care services which people may use in their lifetime, underpinned by the principles of:

- Dignity and respect
- Compassion
- Inclusiveness
- Responsive care and support
- Wellbeing

Staff working in health and social care services therefore should (in theory) have a common understanding of mutual core values.

2.6. The Health and Social Care Divide

An increasing ageing population, economic uncertainty and escalating costs for health and social care have resulted in questions around service sustainability. This is a matter for the whole of the UK (and wider) and not just Scotland where difficult but unavoidable decisions have to be made in terms of present and future provision [110]. Shortcomings in health and social care distribution across UK regions have subsequently received wide publicity. Reports of a 'post code lottery' in care provision has created nervousness in the public domain. [111-114]. It seems the general public understand access to health care; i.e. healthcare is free at the point of access for the most part. However, there is less awareness of social care and its means tested eligibility criteria [92].

The reality of this dichotomy is even more complex and interwoven creating inequalities due to 'a lack of alignment' according to Kate Barker [115 p.2]. For example, NHS funding, whilst under financial pressure, is largely ring-fenced. Social care on the other hand is provided at the discretion of each local authority, is not fiscally protected and is presently subject to severe budget constraints from central and local governments. Additionally, each organisation operates over different geographical boundaries, different legal frameworks, different accountability mechanisms and commission services separately. Blurred distinctions between health and social care cause tensions in terms of who pays for what, termed 'NOMBism' (an acronym for: Not On My Budget) by Lynne Wrennall [116 p 172], which incidentally are also taking up an increased proportion of GDP [117]. Friction has been exacerbated by marked shifts across boundaries between health and social care where changes are heavily tilted through directing patients from free NHS beds to means tested provision under contemporary NHS continuing care [82, 92]. Services are regarded as being at breaking point, and needless-to-say the knock-on effects for clients/patients, their families and carers are distressing and frustrating [17].

Not only is there discord in financial, organisational, geographical, legal and access issues, but also in relation to language, culture and practice [118]. Patient versus client/service user/consumer; diagnosis and cure versus service user empowerment and self-management; contrasting treatment and management of simple/complex cases are just some incongruent examples [119]. Issues surrounding the more powerful NHS versus weaker social care services is described as the tip of the iceberg of what former Secretary

State for Health Frank Dobson described as breaking down the 'Berlin Wall' between the two organisational cultures [120 p.1].

To add insult to injury, at least from a social care perspective is the gulf in public opinion towards each organisation. Nick Timmins of the Kings Fund quotes Peter Hennessey describing the NHS as 'the greatest gift a nation ever gave itself' [92 p.1]. Additionally, Evans and Welling describe statistics that report 90% of the UK population remain supportive of NHS founding principles and 77% were in favour of NHS being maintained in its present form [121]. Conversely, social care services are viewed less fondly 'neither loved nor understood by many and what is understood is widely seen as mean and unfair' [92 p.3]. For example, not all social care needs are met under current legislation and those with even modest savings are expected to self-fund (please see 2.3.2. and 2.3.3.). The Local Government Association gave a stark example where a diagnosis of cancer warrants free treatment under the NHS, whilst developing Dementia does not attract free support from social care – currently the most useful 'treatment' for the effects and consequences of dementia. These remain highly divisive and contentious issues [17].

Social care provision in the latter is therefore at the peril of losing your savings, even your own home. These instances can result in service users having to navigate the social care system themselves without support, leaving the potential for arranging inappropriate provision [17]. Rapid dilution of savings can ensue ultimately leading to becoming reliant on publicly funded resources. There seems a clear need and desire to bridge divisions and thus health and social care integration may be a key means to achieving these aims. No one doubts change is essential however, even past governments admit to being 'not very good at it' [120 p.1]. Achieving an understanding of social care data within and between organisations provides one component that may help to break down the 'Berlin Wall' and make joint working a reality.

2.7. Population Structures

At this point it may be pertinent to ask what factors influenced the decision to integrate health and social care services. This section examines key issues encompassing population structures, fertility rates, life expectancy and population ageing.

It has long been established that mortality, fertility and migration determine human population size and composition [122-124]. When these components are constant, then age distribution is also constant. However, if the age distribution of a population varies over time, it signifies alterations termed demographic transition. Consequences of structural change influence the supply and demand of public and private services in association with important policies of social and economic relevance [64].

2.7.1. Demographic Transition

Demographic Transition Theory Model (DTM) was originally developed by American demographer Warren Thompson (1887–1973) [125, 126]. DTM involves a series of stages that maps population change and helps to explain historical population sizes and compositions [126-128]. The original theory depicted four stages, however Blacker (1947) later enhanced the model by applying a fifth stage [129]. It should be pointed out that stage five is speculative, although some countries such as Germany are already showing this tendency (Figure 4).

Many critiques highlight some shortfalls in DTM. Some argue the model does not take into account the impact of potential migration or future economic, political or environmental incidents. Others claim it is Eurocentric and makes assumptions that all countries will follow suit. However, despite the fact other models exist, DTM is a fitting starting point to help explain demographic changes over time.

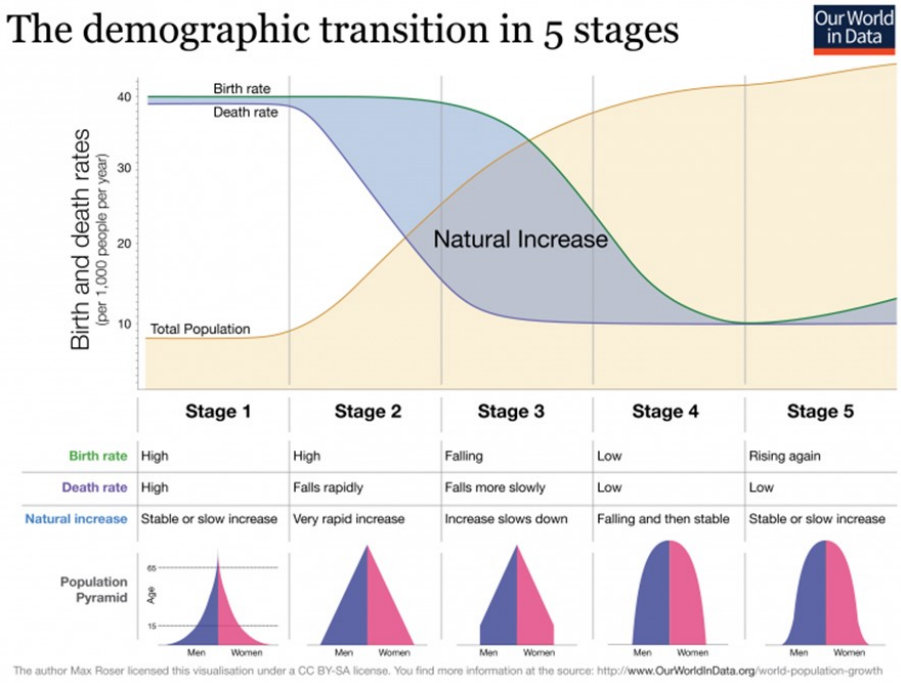


Figure 4. Classic Demographic Transition Model showing 5 stages of population change. Sourced from www.ourworldindata.org with kind permission to use [130]

2.7.2. Transition Eras

DTM depicts population change and shows stages through which developed and developing countries have moved through. For instance, throughout most of recorded history, the global population evolved slowly and steadily, closely connected to environmental conditions and agricultural development [131]. It was not until the Age of Enlightenment and the industrial revolution during the 17th and 18th centuries that rapid acceleration of population growth became noticeable [131-133]. Continued increases throughout 19th and 20th centuries saw the global population reach over 7.2 billion during 2014. These numbers are projected to increase to just under 10 billion by 2050 [133, 134].

Demographic transitions can occur slowly over time, however sudden changes can also happen. Pandemics such as bubonic plague during 14th century (labelled the Black Death) and the 1918 influenza epidemic illustrates how disease and famine impact population size and composition. [135, 136]. World Wars I and II are other examples of precipitous change although recovery from such catastrophes was also fairly rapid. Scotland's population fluctuations of low male population and birth rates following both hostilities are represented in Figure 5[3].

[3] No census was conducted during 1941.

***Population and Age Distribution of Scotland Between World Wars I and II* (1911 – 1921 and 1931 – 1951)**

Figure 5. Population and age distribution in Scotland between World Wars I and II, sourced from Scotland's Census [137].

2.7.3. Fertility Rates

Global fertility rates have reduced by almost 50% from 5.0 to 2.4 children per woman over the past 50 years [138, 139]. This consistency over a 5-decade period suggests the trend is neither fleeting nor short lived. The next 50 years are expected to show global fertility reduce further to 2.1 children per woman [140]. Fertility rates differ considerably between higher and lower income regions, however the decline for both populations is significant and consistent [141]. Higher income countries have witnessed birth rates reduce from 2.8 children per woman to 1.5 between 1955 and 2015 [139]. This trend is echoed in UK where birth rates are recorded at 1.8. As a consequence of lower birth rates and longer lifespans, the UK now has more people over 60 years than under 18 years [142]. Lower-income countries have witnessed a fall from 6.2 children per woman to 2.9 during the same period. This means that by 2050, 75% of the world's population will be living in countries with below-replacement fertility [138].

2.7.4. Life Expectancy

Life expectancy has increased by varying rates between high and low income countries for over 100 years, although the USA reported a slight decline during 2016 suggesting a levelling off period [143]. England also reported a slowing down in 2017 and demographer, Sir Michael Marmot expressed concerns calling it 'historically highly unusual' [144 p.1]. According to UN, WHO and others, although high income countries have undergone transitions in population structure for a long time, developing countries will age much faster [145-148]. For instance, France and Sweden took more than 100 and 80 years, respectively for their older population (65 years and over) to alter from 7% of the total population to 14%. The equivalent change took place over a 25-year period in Japan, from 1965 to 1990 [145, 146, 149]. Japan's life expectancy continues to increase reaching 84 years during 2015 [139, 146]. Developing countries such as, China, The Republic of Korea, Thailand and Brazil are projected to age even faster due to rapid reduction in birth rates [138] (Figure 6).

Speed of Population Ageing

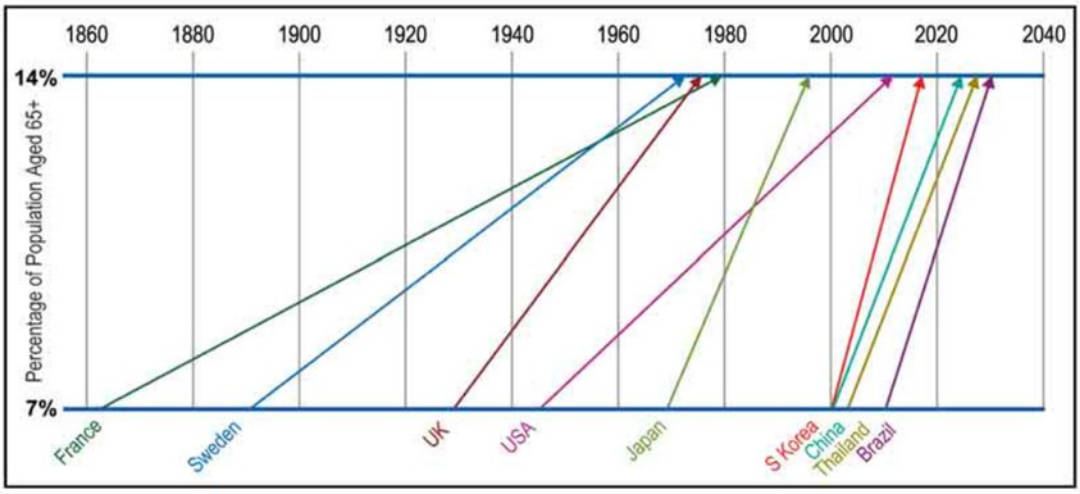


Figure 6. Speed of population ageing from 7% to 14% of total population, sourced from WHO [148].

2.7.5. Population Ageing

As mentioned previously, two major factors other than migration influence population structures; that is mortality and birth rates. Life expectancy is rising whereas birth rates are declining therefore the proportion of older people is increasing around the world [124, 141, 150, 151]. It is this increase in life expectancy that is the key driver for increased demand on health and social care services. The UK population aged 65 years and over has increased by 47% from 1974 to 2014, and now accounts for nearly 18% of the total population (Figure 7) [152]. Additionally, the number of people aged 75 years and over

has increased by 89% during the same period and now makes up 8% of the entire population. The UK's oldest old (aged over 85 years) is projected to double from 1.5 million in 2015 to over 3.6 million in 2037 [153].

Scotland's population follows a similar pattern. The 2011 Census depicts more people over 65 years than under 15 years for the first time. The number of people aged 65 and over has increased by 11% since 2001, now representing 17% of the Scottish population [154]. The Scottish Government projects those aged 75 and over will increase by 82% from 2010 to 2035. The median age is currently 41 years. Older populations in developed countries expect to see numbers expand by the impending retirement of the post-World War II baby boom generation born in 1950-60's [126, 155-158]. As with the rest of the UK, high net inward migration buffers the effect of population ageing in Scotland. The population is projected to fall by 2.5% given zero net migration, but instead should increase by 7% [159].

UK Population Ageing

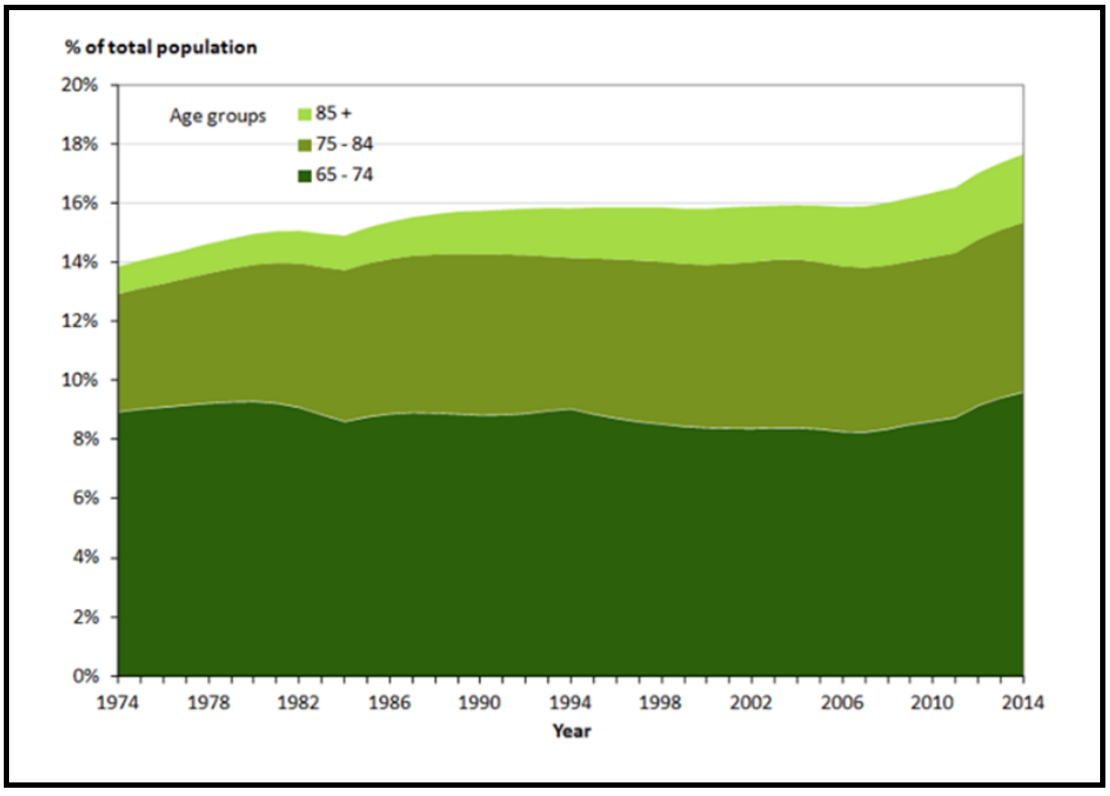


Figure 7. Ageing of the UK population, sourced from ONS [152].

2.8. Characteristics of Old Age

Ageing is associated with progressive degenerative changes in the human body leading to sarcopenia (the loss of muscle mass and strength) and subsequent physical function. Biological deterioration categorised as frailty, and the accumulation of multi-morbidity leaves individuals susceptible to further ill-health and is considered the primary cause of disability and mortality [59]. The likelihood of developing chronic conditions such as cancer, diabetes, neurodegenerative disorders and many more increases with age which has led to a plethora of ageing research over recent years [60].

Other key factors that can impact ageing include modifiable causes such as socio-economic status (SES) and lifestyle choices, meaning that some illnesses can be prevented, or at least delayed. This requires the support of government policy to tackle poverty, socially disadvantaged and vulnerable people. Public health strategies are also required to ensure equal access and provision to health and social care services, health education and the promotion of healthy lifestyle choices. For example, over 4 million people in the UK are currently diagnosed with type II diabetes [160]. Obesity is a prime risk factor for the disease, yet three out of five cases can be prevented or delayed through modest diet control and exercise [161]. It is not surprising then that keeping active, following moderate but nutritious food regime, remaining socially and mentally engaged are amongst some of the simple but key recommendations by the NHS to enable everyone to remain healthy longer, and not just those at risk of disease [162].

2.9. Multi-morbidity

Multi-morbidity is defined by the National Institute for Health and Care Excellence as:

> *'any combination of 1 chronic disease with at least 1 other disease (acute or chronic) or biopsychosocial factor (associated or not) or somatic risk factor or the co-existence of 2 or more long term conditions'* [163 p.1].

Progressive advances in nutrition, sanitation, modern medicine and technology have improved outcomes for people afflicted with previously life-threatening diseases. Consequently, the general pattern for communicable diseases is in decline, certainly for

high income countries. Lower income regions show a slower and more variable pace in reduction between less developed and least developed parts [145, 150].

Yet globally, the reverse pattern is expressed in relation to non-communicable long-term conditions, termed 'chronic diseases' by WHO [164 p.1]. Age carries an increased risk of developing chronic diseases primarily cancer, diabetes, respiratory and cardiovascular illnesses [2, 150]. Couple those with syndromes characterised as the 'four giants of geriatrics'; urinary incontinence, falls, immobility, neurodegenerative/mental health disorders captures the myriad of complex and specialised services that will be required to meet the almost inevitable demand [141 p.43) (165]. Individuals suffering from more than one of these conditions can be termed multi-morbid.

Current research indicates the prevalence of multi-morbidity is increasing [166]. One study published in the Lancet examined data from 1,751, 841 patients registered with 314 medical centres in Scotland (over one third of the Scottish population). The study found that 42% of patients held a diagnosis of one or more chronic condition. More surprising was the revelation that 23% were multi-morbid [167]. Furthermore, multi-morbidity was not confined to older people. The overall number of people with multi-morbidity aged <65 years was greater than those aged >65, although the proportion of older people with multi-morbidity was higher. Although older people will remain more likely to require health and social care than younger people, the burden of multi-morbidity and its consequences in terms of disability and the need for health and social care will also be felt by those aged <65. The Kings Fund think-tank supports this view in their report which highlights increased applications from working age people for long-term local authority social care in England [168]. These younger multi-morbid patients will become the next generation of our older population. This added pressure to already stretched health and social care services signals challenges of unprecedented proportions.

2.10. Global Burden of Disease

Scotland and indeed the UK as a whole are not facing this crisis in isolation. During 1990 WHO produced a framework for calculating the global burden of disease to assist with consistent comparative analyses of diseases, injuries and associated risk factors

across regions, countries and continents. Since then the Global Burden of Disease (GBD) project introduced new measurements such as disability-adjusted life-year (DALY) and Comparative Risk Factor Assessment (CRA) to existing mortality and morbidity figures [169]. Other academic collaborators have further developed the project where in 2010 the Institute for Health Metrics and Evaluation applied new methods for calculating DALY's which were incorporated into the GBD project publication of 2012 [170]. The UK published its associated report in 2015. The document revealed that although people are living longer, their years lived with disability (YLD's) through chronic diseases such as heart disease and diabetes has also increased [171].

2.11. Function, Disability and Health

The International Classification of Functioning, Disability and Health (ICF) offers a standardised language framework for the description of health and health-related conditions [172]. ICF fits alongside International Statistical Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which catalogues codes for all known diseases, signs and symptoms [173]. Publications are designed to enable a universal tracking system of health and illness meaning that trends in diseases can be monitored for clinical, governmental and research purposes. In essence, ICF classifies health whereas ICD-10 classifies illness.

WHO takes a holistic view to classify changes in body function from a biopsychosocial perspective to which the UK and others have adopted [172]. An individual's biological, psychological and social status are greatly interrelated where neither one element on its own is sufficient to conclusively lead to a health or illness state. This is a significant shift from previous concepts where two predominant models existed; the medical and social models of health. The medical model focused on the presence or absence of disease to categorise health placing an emphasis upon diagnosis and treatment with the aim of curing. Disability was regarded as a separate entity perceived as incurable. Conversely, the social model viewed health and disability as a socially constructed problem, laying the responsibility for modification of social and environmental issues firmly in the hands of governments and policymakers.

Contemporary health problems do not fit the narrow framework of either model sufficiently, although each model has merit. For example, a diagnosis of disease on its own whilst important does not take into account social or environmental matters. Similarly, the social model does not allow for the fact that not all diseases are preventable irrespective of direct efforts to control social, environment or economic determinants. These somewhat out-dated models largely reflect historical healthcare configurations.

WHO acknowledge that all individuals can experience a decline in health and thereby experience some level of disability. Hence, integrating medical, psychological and social aspects such as through health and social care integration can provide a clearer view of the diverse dimensions of health. Similarly, as mentioned before multi-morbidity is becoming more commonplace therefore a collaborative approach can be considered a more desirable path which can be achieved through formal collective appraisal and judgement. Health and social care integration is thus designed to address function and ability, not just diagnosis and disease.

2.12. Routine Data

Collecting data is integral to the regular management of any contemporary company or business entity be it a national or local conglomerate, advertising network, e-commerce website or government organisation [174, 175]. Routine data are collected through administrative processes and can help to inform historical and current performance, as well as to enable future business planning to accommodate shifts in trends, market forces and resources [175]. Health and social care organisations are no different where vast amounts of information are gathered through mechanisms such as in electronic patient/client records, national census data and health and social care surveys [176-178]. From a social care perspective, to which this thesis is the main focus, social care staff conduct an outcomes focused assessment (also known as self-directed support [SDS]) to determine eligibility for service provision [179]. A wealth of information is collected at this point including personal, financial and demographic data. An assessment also establishes clients' wishes and includes notes of their physical, psychological and housing needs and builds knowledge of their existing support network. These data are gathered alongside details of any subsequent care provision. Future assessments, changes or closure of service provision are also recorded, generating wide-ranging records that provide an individual trail of a client's entire social care journey.

With such a rich source of data, there is great scope to use this information in research to inform individual, service and population level (local, regional, national) activity. These three levels of data are important in order to fully understand social care. They have the potential to map individual client pathways and also to explore access to services from numerous perspectives such as establishing who requests social care, what services are provided, and where are these services delivered. Analysts can make comparisons between individuals and populations by combining variables to investigate provision type, socioeconomic differences, localities and other characteristics such as age, ethnicity and care home use. Data can highlight what works for whom, when and how through systematic analysis of outcomes measurements captured in social care's record management systems. Longitudinal studies can also be conducted since data have been collected over a number of years and continue to do so. Changes in service access and use over time may highlight weaknesses or gaps in service provision.

The value of routinely collected data is that they already exist and are normally updated over long periods. Costs associated with their use are therefore, minimal particularly in relation to the expensive alternative; gold standard randomised controlled trial (RCT) [(174)]. RCTs currently differ from routinely collected data studies in many ways. For instance, most routinely collected data studies do not have to meet the numerous regulatory requirements that need to be fulfilled prior to the commencement of an RCT, such as the ethical implications of randomisation. Additionally, routine data normally comprise much larger sample sizes offering opportunities to strengthen representativeness and external validity through generalisable findings. Using routine data also offers less ethical dilemmas associated with access to hard to reach participants such as the elderly or vulnerable people providing a 'real-world nature' depiction [(180 p.2)]

Using routine data however are not without pitfalls and can bring challenges in that people using these data have no control over what data are collected and how. Additionally, analysts may not hold local knowledge that might explain potential anomalies in data-sets. There can be limitations in accounting for accuracy and completeness as Powell and colleagues report in their evaluation of routinely collected healthcare data [(181)]. Although, Hemkens *et al* report the benefits clerical review of raw data can offer which result in improved data quality to mitigate some biases [(182)]. Classification and coding practices can change over time which may not be comparable.

For instance, Davies *et al* found the change of versions from ICD-9 to ICD-10 limited findings in their analysis as did the introduction of 'hospice' as new place of death category [183]. These examples are extracted from healthcare publications however, the same principles apply when considering social care data. For example, at the beginning of this study, it became known that two local authorities in Scotland had entered into a formal agreement to share funding resources for adult health and social care. Any analyses between these two districts would not be possible unless some variable had been entered into their reporting systems to differentiate between the two areas. Additionally, when comparing over time and across other districts, data would either have to be retained as separate entities or previous isolated entries joined so that comparable evaluations could be made.

Despite these challenges, social care data is a potentially valuable resource which can assist analysts, policy makers and service providers to understand social care. It is crucial users of these data are aware of the strengths and weaknesses of datasets and the context that lies behind them in order to avoid the dangers of making incorrect or misleading assumptions from findings.

2.13. Influence of Technology

The digital era has come a long way since the days of British born visionaries Charles Babbage (1791–1871) and Ada Lovelace (1815–1852) known as the father of computers and the first computer programmer respectively [184]. Since then, computer science has grown considerably meaning that efficiencies in speed and storage capacity have resulted in super computers. High capacity and performance, large scale data handling systems and networks allow the UK to remain a global leader in research. Great opportunities for solving complex problems across all sectors of industry, commerce and science are now possible, including healthcare informatics approaches characterised by 'big data' and the use of data linkage techniques. Data linkage is a process which brings together multiple data sets from different sources for example, surveys or routinely collected health and social care information [185]. The practice allows researchers to perform analyses which would otherwise be impossible from isolated data sets.

The Scottish Government recognises that in order to obtain a robust evidence base that supports planning, delivery and comparison of its services, effective information systems are necessary. Consequently, Information Services Division (ISD) Scotland in collaboration with Scottish Analytical Services Division (ASD) and other stakeholders have been commissioned to develop individual and longitudinal datasets, information governance, IT solutions and analytical outputs [(23)]. Their objective to improve the quality, depth and consistency of datasets is ongoing and involves a broad range of routinely collected intelligence sources for example; economic, welfare, population, health and community care data.

Whilst this work continues moving forward, one of the projects, Health and Social Care Integration and Intelligence project (HSCIIP, renamed SOURCE in 2017) has incorporated nine core Health and Wellbeing Outcome measures to gauge improvement [(186)]. Each integration authority is required to submit quarterly performance reports to the Scottish Government in a standardised format ensuring consistency. This is vastly different to the previous *modus operandi* where information reporting was inconsistent. Reports are supplemented with a Core Suite of Integration Indicators alongside contextual information to provide a wider picture of localities [(187)]. Government assessors are then able to analyse local, regional and national similarities and differences in health and social care. Pre-existing reporting measures continue such as NHS Local Delivery Plan (LDP) standards which replaced NHS HEAT (Hospital Efficiency and Access Targets) [(188)]. In a similar vein, local authorities report Community Planning (CP) measures from Single Outcome Agreements (SOA) also known as Outcomes Focused Assessments (OFA) which also serve as a basis to ensure rich and robust evidence underpins policy, practice, planning and decision-making [(189)].

To help drive programmes that support strategic planning and decision-making, and to meet the needs of health and social care integration, access to and sharing of data from these various sources are required. Joining such data across and within health and social care sectors has the potential to provide a clearer understanding of service use, efficiency and future provision. Innovative progress in information technology (IT) makes it possible for health and social care data to be combined through these data linking strategies.

The Scottish parliament and others have identified notable cultural, organisational, procedural and technical barriers relating to information sharing and linking [39, 190-192]. For instance, different social work departments collect information in different ways and the reasons behind coding decisions are currently unclear. Issues surrounding documentation, culture and workflows are also evident particularly in relation to routinely collected social care data [39]. Social care data is under developed, it has not yet been subject to in-depth evaluation to date, and thus our understanding of this information is limited [21, 22, 38]. On the other hand, current knowledge of health care sectors reveals extensive literature alongside rigorous examination of NHS National Programme for IT (NPfIT) which highlight strengths and limitations of health care information [26-30]. If health and social care integration is to prove successful, and data from these sources are to be used and linked for analyses, a deeper understanding of social care data processes, flows and uses are required [22].

2.14. Summary

The literature offers an extensive range of factors to justify the imperative to evaluate social care data in Scotland. The chapter presented a brief history of NHS and social care services in the first instance highlighting differences in origin, function, practice and ethos to bring an understanding in context of how health and social care integration and social care data in particular impacts the Scottish Government's vision for 2020. Other factors that heavily influence health and social care integration have been documented to offer a holistic perspective to the rationale behind the study. For example, demographic transitions, declining fertility rates and improvements in social and medical determinants of health combine to result in greater life expectancy and hence our ageing population. The chapter concludes with the Scottish Government's analytical plans which demand data from reliable sources in order to provide robust and meaningful results. Since social care data are underdeveloped in comparison to healthcare information, there is an urgency to address this imbalance. The next chapter describes the methodology applied to evaluate social care data through a multiple-site ethnography involving three local authorities and their associated health board in Scotland.

3. CHAPTER 3. METHODOLOGY

3.1. Introduction

Key factors from chapter two suggest that social data in Scotland would benefit from a comprehensive evaluation in order to provide insight and understanding of strengths and weaknesses, particularly with regard to health and social care integration. Health care data are well established and understood in contrast to social care information. There is therefore a pressing need to explore how social care data are created, processed and managed in order to address the disparity in knowledge and understanding between the two organisations. This is particularly pertinent given the formal integration of health and social care services. This chapter outlines the aims, rationale for, and design of an ethnographic study to achieve this. An overview of aims will be presented before introducing ethnography as both a methodology and method incorporating Actor Network Theory (ANT) and the Sociology of the Professions as supporting theoretical frameworks.

3.2. Aims and Objectives

The aims of the study are to explore processes involved during routine social care data collection to uncover the practical and contextual aspects that influence everyday practices. This involves investigating the views and experiences of individuals from executive and managerial staff through to front line social workers, administrative personnel and IT data managers:

Aims:

To build a comprehensive understanding of entire social care data collection processes and management.

Objectives

1. To explore how routine data are collected in the first instance; this includes investigating how information is gathered at the outset during client/patient assessment in the community and also in acute or community hospital settings.

2. To examine how social workers record and code this information. Particular consideration is given to finding out how social workers make judgements during assessment and what factors influence decision-making processes.

3. To establish how data flows through systems (IT and organisational) and also how data are used and shared within social care and between various other agencies.

In order to capture a full representation of data processes, the study examines social care data collection and management processes through the lens of older people and social care professionals/managers. The rationale behind this pragmatic approach lies with the knowledge that age carries an increased risk of ill-health where a great number of elderly people will require support from a wide range of primary, secondary and tertiary care services [59-61]. This is often coupled with the need for social care involvement either by a variety of short-term measures or a long-term package of care [62, 63]. A focus from this perspective will provide a comprehensive view of the many different services involved in health and social care integration, encapsulating multidimensional data pathways.

3.3. Definition of Ethnography

There are many instances in the literature where the word ethnography overlaps with a host of other descriptions. Terms such as qualitative enquiry, fieldwork, interpretive methods, life history, thick description and case studies are used synonymously to explain a variety of approaches [193-196]. In essence, ethnography is both a methodology and a family of methods to describe and understand communities and cultures. These can include studying society through activities such as observation, individual or group interviews and also by utilising artefacts such as photographs (including film), maps, letters and other documents [197, 198]. Importantly, it is a methodology that adopts a particular approach to understand the social world holistically and contextually from the perspective of the people themselves through detailed in-depth engagement and in being there in the moment [199].

3.4. Brief History of Ethnography

The discipline of ethnography evolved from social anthropology during the 19th century and the years of colonialism [200]. Traditionally, ethnographic accounts were documented by explorers, travellers and missionaries who wrote about other cultures (normally in remote locations), and described how native norms, beliefs and values influenced their communities. The social organisation work of anthropologist Bronislaw Malinowski is arguably the most influential commentaries, certainly from a British perspective. Malinowski discarded the evolutionary explanation for societies and instead embraced a sociological view [46]. Later, and largely through concerns with the impact of urbanisation and industrialisation, Western sociologists became interested in understanding communities and populations closer to home during the 20th Century [46]. Social interactions and perceptions of people, groups and communities became the focus of much attention through a series of projects such as the Middletown and Hawthorne studies of the 1920s and 1930s [201, 202].

The Chicago School was another pioneer of contemporary ethnography and studied race, immigration, politics as well as marriage and family issues during the 1920s-1950s, a time of rapid social change especially during the depression years [200]. This type of work spread to Europe and gradually became more common. Many social research studies are now conducted in corporate, industrial and health and social care organisations in an attempt to understand complex inter/intra relations and every day order and meaning between managers, staff and clients [203].

3.5. Epistemology and Ontology

The methodological base of ethnography originates from naturalism and the humanistic model, sometimes also called interpretative or hermeneutics which contrasts with the natural science and positivistic models of social research. For instance, ethnography looks at social context from the participant's perspective to gain an insider's view of their social world, seeing and telling it as it is, and being 'true to the natural phenomena' [47 p.37]. The process is intentionally unstructured, flexible and open-ended to examine the social world from an insider's perspective and to accept their knowledge, practices, experiences, understandings and explanations without prejudice.

The aim of this enquiry is to explore how social care data materialises within this multi-layered organisation and hopes to result in a here and now appreciation of how data are collected, how data are coded, used, shared and more importantly what those data mean. As a researcher, one has to be mindful however, that each investigator brings their own epistemology and ontological views which may influence how the social world is witnessed, sensed and experienced which sceptics suggest will impact analysis. This is a major criticism of ethnography and has been the source of many hotly contested debates even from proponents of the discipline who regularly query theoretical and methodological positions [(47)].

In response to such critiques, one could argue that ethnography places an emphasis upon individual meaning, context and self-reflexivity whereas a quantitative approach stresses an importance on numbers, generalisability and control [(204)]. These are two diverse and conscious standpoints, epistemologically and ontologically, which can be applied to answer different types of research questions. Ethnography can illuminate meaning to the how and why in context whereas a quantitative approach can investigate the what, complementing each other [(205)]. A quotation often attributed to Einstein but later acknowledged to sociologist William Bruce Cameron [(206)] sums up quite nicely the virtues of an ethnographic approach contrasted with a quantitative method; 'Not everything that can be counted counts, and not everything that counts can be counted' [(207 p.13)].

3.6. Key Concepts of Ethnography

This study takes the view that ethnography can provide a better understanding of this area of interest by adopting one of the key concepts of ethnography, reflexivity. [(199)]. As Madden reminds us, 'Ethnography is a whole of body experience. Because of this it is important for ethnographer's to be reflexive' [(199 p. 34)]. Reflexivity is a vital practice to interrogate potential bias introduced by the researcher's background. It is a method to understand and control for personal influences that may be brought to the research. Reflexivity also permits the re-examination of phenomena in a relational context thereby revealing multiple interpretations that when considered give a deeper insight of how we might understand events and behaviours. To further quote Madden, reflexivity 'allows for the dissolution of the putative opposition to objectivity and subjectivity, and can help to resolve the apparent contradiction of participant observation [(199 p. 34)]. In other words,

reflexivity helps to provide a reliable and valid account of events through rigour of methods.

Reflexivity in ethnography allows a researcher to consider knowledge gained from participants both in context and also in their role as a researcher [199]. Attitudes and beliefs of both participant and researcher must be carefully contemplated to make allowances for nuanced information and social processes that may encroach and shape data [47]. Such instances require a critical attitude towards for example, the location of the research, power relations in the field and also the wider relevance of the setting and subject matter. Being reflexive also brings a sensitivity and attentiveness to events or instances during relationship building between participants. Similarly, language use, intonation, appearance and bearing are all factors which can unwittingly influence responses during interviews or observations. Equally, such responses can also influence further lines of questioning [208].

This iterative-inductive approach allows the study of real-life situations in a manner that is not manipulated by researchers. That is to say researchers observe social interactions that occur within groups of people, communities and organisations through seeing, listening, sensing and experiencing the daily ebb and flow of their social and cultural world [47]. This has been conceptualised as 'being there' and being simultaneously 'in' but not 'of' the other culture [195 p.2]. In contrast, a deductive approach normally refers to a positivistic view of traditional empiricism whereby settings are controlled by the researcher and quantitative measured variables are statistically analysed to find associations [199].

There is however, the argument that social contexts are always influenced by researchers in one way or another [209]. Therefore, a key role of the ethnographer is to spend as long as possible 'being there' and integrate into the setting, alongside being reflexive about the impact their presence has on the setting. An ethnographic approach provides flexible and reflexive characteristics to garner information in a manner not realistically attainable through quantitative means. There are different approaches to collecting information in ethnography mainly through semi-structured or structured interviews (individual or group); participant or non-participation observation; surveys and field notes [47].

Each method serves as a means to provide insight to the phenomenon of interest. For example, structured interviews involve planned closed and some open questions which are presented to participants and are set in stone, whilst semi-structured interviews allow latitude to explore other verbal reports or meaning [47]. Participant observation involves the researcher having a role in activities which some argue can influence the outcome of the observed event, whereas non-participation observation purely observes happenings [196].

Survey methods are questionnaires, either self-administered or conducted by researchers which can gather information in a systematic manner and are cost effective and timely. However, there is a risk that socially-desirable bias may be introduced. This is where participants feel they are unable to respond honestly, or feel they will be viewed unfavourably when providing answers [196]. Standardised responses aid speedy analysis however, such responses cannot easily capture subtle nuances and context related matters of our complex social world. There are advantages and disadvantages to each approach and so for this study a combination of semi-structured interviews and non-participation observation incorporating field notes and documentary analysis were selected to offer an open-ended and holistic sense to the investigation [50].

Previous reports acknowledge increasing use of these techniques in health and social care and other organisational research to afford deeper insights into contemporary society and all its complexities [49, 50, 210-212]. Although still considered under-used by some authorities, projects of this nature can uncover implicit or hidden associations through 'being there' to bring a new awareness of how individuals and organisations function [195 p.2] [210]. Importantly, such projects also provide insights into how organisations work from the perspective of the participants themselves through the epistemological approach adopted. This bottom-up line of enquiry allows engagement with every day actors and not only those of authority or salience [213].

3.7. 'Being There'

The following is a quotation from Robert Park, a notable sociologist from the Chicago School of the 1920's speaking to undergraduate students at the University of Chicago. And whilst a somewhat out-of-date rhetoric is presented, the extract captures 'being there' in ethnography [47].

> *'You have been told to go grubbing in the library thereby accumulating a mass of notes and a liberal coating of grime. You have been told to choose problems wherever you can find musty stacks of routine records. This is called 'getting your hands dirty in real research'. Those who counsel you thus are wise and honourable men. But one thing more needful: first hand observation. Go sit in the lounges of the luxury hotels and on the doorsteps of the flop-houses; sit on the Gold Coast settees and in the slum shakedowns; sit in the orchestra hall and in the Star and Garter Burlesque. In short, gentlemen, go get the seat of you pants dirty in real research.' (47 p.13)*

'Being there' is an important concept to consider for this particular study where exploring social care data processes, practices and their meaning were the primary aims. 'Being there' can help negate the potential for discrepancies to occur between participants in what they say they do and what they actually do, and more importantly why (202). This was exemplified during part of the final phase of the Hawthorne studies (see 3.4.) when Western Electric Company under the design of William Lloyd Warner, a student of the renowned Alfred Radcliffe-Brown conducted what became known as the Bank Wiring Observation experiment (214). Participants described how they completed their work sheets when being interviewed. However, researchers later observed workers manipulate job-sheet figures and attributed completed jobs to other workers who could not work as fast, contradicting their original statements (214). This example enabled researchers to understand why these discrepancies occurred and what the motivations were for their actions.

3.8. Step-in-step-out Ethnography

The literature describes conventional ethnography as being conducted over prolonged periods of time, sometimes years immersed and co-residing in a culture or community to define a group/setting (199, 215-218). This type of ethnography still exists today however, contemporary studies are just as likely to be conducted over short periods without the need to live alongside the group or community of interest (199, 211, 219, 220). Common instances where this type of approach can be used normally occurs where multiple sites

are involved or when the research is taking place in the ethnographer's own native space. This has been referred to by a number of terms; 'step-in-step-out ethnography' [199 p.80]; 'short-term ethnography'; 'rapid ethnography'; 'focused ethnography' [221 p.352] . The strategies and means to an end remain the same in terms of getting to know people, being simultaneously 'in' but not 'of' the other culture [195 p.2].

The amount of time spent in a field is one of the key differences of this approach; usually weeks or months, rather than years [221, 222]. A key criticism is that it is far more difficult to develop a trusting relationship with informants given these temporal differences. However, traditional methods relied upon simple tools and much 'hanging around waiting for things to happen' [221 p.355]. Modern technologies and techniques allow more intense observational experiences through different uses of data collection processes and analysis tools. For example, constant active engagement with participants at the heart of the action can occur where the research purposes are clearly expressed to participants and provide a more concentrated involvement to seeing the routine every day. Additionally, the contemporary research space negates the need to fulfil the traditional long-term commitment of an 'apprenticeship' in seeking to understand a remote community or group setting [221 p.356]. Operating from a more familiar native environment offers the ability to immediately focus on the phenomenon of interest since some knowledge of the field in question is already gained. Madden warns however, not to rush the ethnographic process which may prove perilous if some experiences are missed or forgotten. This warning applies no matter the length of time in the field but may be more pertinent during short-term ethnography since time is often of the essence [222].

Some ethnographers however may see the notion of this step-in-step-out approach as detrimental to the research process since immersion is compromised [199]. Yet total immersion cannot practically be achieved even in conventional ethnography. For example, Madden quite rightly points out that good ethnography involves extensive periods of time to write up field notes, meaning time away from engagement [199]. Additionally, time is spent contemplating events through being reflexive, a process normally conducted alone. Being with people is therefore partial immersion albeit sufficient to remain directly engaged and provide reflexive representative accounts [199]. Step-in-step-out ethnography thus provides similar levels of in-depth engagement sympathetic to the aims of conventional ethnography. As mentioned earlier, this

iterative-inductive approach accepts that the behaviour of individuals and groups must be understood within their 'natural' not 'artificial' setting and in context [46 p.7]. As Brewer maintains, a hospital, school or street corner is as natural a setting as any remote community or distant native, albeit conducted in a different context with different tools [47].

3.9. Actor Network Theory (ANT)

Actor Network Theory was inspired by socio-technical theories of the 1970s and 1980s and is a sociological approach to understand and explain social life. ANT has also been considered in other terms; the Sociology of Translation, Co-Word Analysis and Actant-Rhizome Ontology [223-225]. It was chiefly represented by Bruno Latour, Michel Callon and John Law who challenged the traditional and contrasting concepts of primacy between social structure and agency firmly held by Western sociological intellectuals [223, 226-230]. For example, many theorists have debated whether society is determined by organisational structures or human behaviour resulting in a variety of theoretical philosophies. Classical writings by Emile Durkheim [231] and Max Weber [232] depict these contrasting views. On one hand, Durkheim believed social structures were dominant and responsible for individual behaviour. On the other hand, Weber considered society was constructed primarily through the judgements and actions of human agency. More contemporary sociological thinking attempts to resolve this conflict by finding common ground from both theoretical positions such as in the writings of Giddens and Bourdieu [233, 234]. The following is a quotation from Latour highlighting what he perceived the meaning of society contradicting long-established social theory.

> '*Social is not some glue that could fix everything including what the other glues cannot fix; it is* ***what*** *is glued together by many* ***other*** *types of connectors.'* [227 p.5].

ANT was developed as a toolkit rather than a theory and dismissed the conventional notion of social relations being independent of the natural and material world [235]. Instead, ANT proponents see no division between human and inanimate objects in how the social world is created [227]. In other words, the social world is performed simultaneously by ever changing human and non-human relations. Equally important is

the view of constant change with networks being shaped and re-shaped [235]. In this respect, Law perceived this as being able to 'see the relative messiness of practice' meaning that knowledge is constructed by complex connecting processes, devices, artefacts, as well as humans to encompass a whole range of what he called 'active participants' [235 p.18]. Human and non-humans are treated equally and examined purely in terms of their mutual inter-relatedness.

Latour prefers to use the term 'actant', referring to either a person, an organisation, a piece of machinery, IT, ideas, or even vegetation [227 p.54]. Latour discusses what he refers to as 'the heterogeneous nature of the ingredients making up social ties' meaning that a series of actors or actants (human or non-human) interact to create a network [227 p.43]. Networks develop as either stable or unstable entities depending on what associations are present, how they change, and how parts of a network form another network to accomplish stability or otherwise. ANT accepts that any actor introduced or removed from a network, influences how that network functions.

ANT is a therefore a valuable approach to explore social care data collection, coding, use and management since equal precedence is afforded to human and non-human objects that actively participate in networks. Exposing anticipated but also unpredictable outputs from network tracing activities is therefore possible. It is clear multiple socio-technical processes are at force during social care data process. For example, local authorities, health board organisations/structures, IT systems, data managers, client records, social work and clinical staff interconnect in multiple ways during information creation and management. ANT is particularly useful to help tease out every day work flows and networks at force. Network compositions could include for example, clients who have been assessed by social work staff who then become part of a larger network through their inter-relatedness with social care workers. They then become part of a larger network through their interaction with care providers. Equally, this larger network can become further interrelated through client data being stored on local authority and health care data bases.

As with all other social theories, applying an ANT approach faces challenges where even Law reminds us ANT remains a 'heterogeneous work in progress' [236 p.9]. Additionally and as Walsham reports, 'any new social theory which receives significant attention

tends also to attract criticism, and actor-network theory is no exception to this'. [237 p.472]. He further urges anyone considering using the approach to be aware of its usefulness and of course its limitations.

3.10. Key Concepts of ANT

ANT can be applied to study any type of organisation or place where objects or technology and other inanimate entities come into being. Actants can therefore be followed in order to identify networks at play and their effects on social practices and also how social practices impact networks. For example, ANT has been used to understand the role of technology in healthcare settings; in identifying the mechanisms of quality improvement in long term care; in examining patient experience data and in appraising the implementation of complex Project Management Information System (PMIS) [238-241]. Additionally, Stoopendaal and Bal illustrated how improvements occurred to prevent malnutrition in older people living in residential settings [239]. Through tracing human and inanimate objects, their study discovered many interconnected networks that varied from national policies, quality improvement collaborations, information gained at conferences and manager/staff/family training, to tablecloths, folded cloth napkins, new dishes, ambience, resident preference of meals, weighing scales and computer systems. The exposure of complex but different interrelated networks through tracing resulted in multiple successful translations and inscriptions. Practitioners and practices were changed through training and professional reflection to enable new routines. These new routines were bolstered by the introduction of new crockery and meal delivery, providing visual and other sensory confirmation of change. Changes to routine procedures were inscribed in documents such as protocols to make new procedures durable. Stoopendaal and Bal recorded the words of Garfinkel (1967) to explain how 'improvement can come alive through tiny, mundane details [239 p.84].

The number of actants and networks can be infinite in theory, and so from a pragmatic point of view, researchers are guided to follow the dominant features of the action to answer the research question, or as Callon writes '*primum movens*' (prime movers) of the story [223 p.203] [238] . Taking this slant, social care data collection, coding, use and management are the focus of attention. According to Latour, actants can also be viewed as networks. For example, if we take a social care IT system, besides being an actant in

a larger network of a local authority organisation, it is also a network in its own right. The network involves actants such as a systems design engineer, a catalogue of instructions, specific terminology, software and hardware, electricity supply, client information, operators and office space. Essentially, everything can be both an actor and a network [226, 229]. Therefore, depending on how these units are associated during interaction will depend on their role and thus the stability or instability of the network.

Some critiques highlight that there is a lack of robust guidelines in terms of who and what to include/exclude in the continual process of following actors in management and organisational studies [242, 243]. Following prime movers was viewed as being of limited assistance to ANT researchers leading to a whole range of related questions [244]. For example, when critiquing the innovative guided transportation system intended for Paris in the 1990s, Peter Miller is scathing (if entertaining) of Latour's book 'Aramis or the Love of Technology' referring to the publication mockingly as 'A murder story with no murderer!'[244 p.361]. What seemed clear was his concern for which actors to follow and where to stop. Miller concludes 'There is more than one Aramis story out there waiting to be told, more than one technological project to be described [224 p.363]. Additionally, but without explicitly stating so, Miller considers ANT far too descriptive suggesting a lack of expansion, whereas other concepts may be more straightforwardly applied out-with actor-network but in conjunction with network tracing activity [245]. In keeping with Walsham's recommendations, ensuring an awareness of ANT's usefulness and limitations can be facilitated by understanding its key concepts [237].

3.10.1. Black-Box/Punctualisation

ANT is underpinned by three specific and unique concepts that will be employed in this thesis; Black Boxes, Heterogeneous Engineering and Translation [227, 229, 246]. Black-Box is a concept originally used in technological studies which simplifies the complex to individual parts in order to give an understanding of network and system flows [229, 247]. Referring to the example of an IT system above can help to explain further. For instance, many lay people will know very little of the structures and workings of an IT system. We will often take for granted that a system operates as expected with no second thoughts on the matter. Inputs and outputs are all that are required. Law refers to this as 'simplification', its integrated components judged invisible or so called 'black-boxed' [229 p.385]. However, when an IT system crashes, this previously concealed 'black box' of

information emerges as an accumulation of different parts and ingredients enabling examination of the ways in which these components assemble as a whole. This concept was articulated by Nimmo in his socio-material history of dairy milk in UK, and through ANT his analysis was able to render the invisible visible providing a social, economic and political portrayal of the modernisation of the UK milk industry [248]. In relation to social care data collection processes, exploring black boxes can reduce a network to individual parts, exposing the ingredients making up the whole, be it a servicer user, a joint working team, an IT system, or an organisational structure.

Law used the analogy of a healthy person whose body function is hardly noticeable until something occurs, for example ill-health [229]. When illness strikes, the body is transformed into a larger complex network involving (although not limited to) actants such as GPs, surgeons, healthcare staff, hospital setting, operating theatre, scanners, medication prescribing and patient records. These interactions are termed punctualisations whereby actor-networks interlink with other networks to create larger actor-networks. From the example above, the body (a network) became inter-related with hospitalisation (larger network). The process of punctualisation 'converts an entire network into a single point or node in another network' [249 p.153]. Thus, in terms of social care data, the client/patient is a network in his or her own right. When social care services are required, the client/patient becomes inter-related with another network including but not limited to; social workers, AHPs, the assessment process, care package provision and record management systems, ultimately forming a larger network of networks.

3.10.2. Heterogeneous Engineering

As previously mentioned, ANT authors see 'knowledge' as entrenched in 'heterogeneous materials' of the social, the technical and the natural and that there is no 'a priori'. In other words, no precedence or assumptions are made to either objects or people and their effects on the social world. [229 p.381-382]. Rather, social relations may shape systems or systems may shape relations and any separation, expectations or predictions are negated [223]. From a social care data perspective, information gathered influences what subsequently happens to a client, for instance the provision (or not) of a care package. Equally, what happens to a client impacts what data are collected for example, in planning future services, changes to policies, structures and organisations. These mutual influences were exemplified during Desai and colleagues' study of patient

experience data where the application of ANT enabled them to better trace how and in what circumstances led (or failed to lead) to quality improvement [240].

Engineers may be viewed as systems builders but from an ANT perspective are viewed as social, technical and natural constructors in the wider scheme of commercial, industrial or governmental organisations. Heterogeneous Engineering is the tracing of these actors and networks to enable an understanding of how elements are organised, stabilised and combined to create the interrelation that they do, examining what influence is exerted, and in what direction [246]. This concept is particularly relevant to social care data since although data are collected from clients and the provision of services operate successfully much of the time, they do not entirely, or standards fall below what is expected from modern health and social care. Thus, vulnerabilities during breakdown can be traced using this view.

Some appraisals question an emphasis of micro structures of society over the macro[4] in opposition of ANT's abandonment of the a priori divide, viewing the concept as being in conflict with one another [242, 250]. However, Latour argued that macro structures of society are comprised of the same basic building blocks and connections as micro structures which can therefore be examined in much the same way. Or as Latour simply notes 'the macro-structure of society is made of the same stuff as the micro-structure' [251 p.118]. He further adds that the tier change from micro to macro and vice versa is exactly what researchers should be able to document [251].

3.10.3. Translation

Translation is the term given to describe meaning to a process in which one thing is turned into another. For example, a simple intermediary (actant) passing through a network, performing as intended, sharing space in harmony, is considered aligned and a 'perfect translation' [223 p145]. Simple intermediaries pass through a network, without stopping and perform as predicted. Or as Latour explains 'An intermediary, in my vocabulary, is what transports meaning or force without transformation: defining its inputs is enough to define its outputs' (a black box) [227 p.39]. Conversely, the further from

[4] In this context, macro structures refer to overall high level social structures, systems, and populations whereas micro structures focus on smaller groups or settings, typically at community or individual level viewing everyday lives and experiences.

affiliation and agreement the more likely an unsuccessful translation will occur. For unsuccessful translations to materialise involves the introduction of a mediator; intermediaries that cause others to do unexpected things [227]. Translation in this context can be thought of as the wide-ranging movement of mediators over time and space, generating transformational change. These two configurations can be symbolised as follows.

Simple Intermediaries ***Mediators***

ANT accepts actants as fluid entities, making and re-making networks. Callon refers to the 'circulation of intermediaries' to define and describe actant interactions which give shape to a network [249 p.140]. Researchers are urged to 'read' the intermediaries metaphorical 'inscriptions' to determine if they are simple intermediaries [249 p.140]. The key point here in relation to social care data is that as part of a complex system, actants often perform unpredictably, thus examining translation can identify successes as well as collapses in social care data processes. Cresswell and colleagues provided an interesting example when they examined the implementation of the electronic patient record across multiple sites in England [238]. For instance, one of their findings regarding the successful uptake of new IT systems was dependent upon the age of an operator. One example referred to a retired GP who had returned to practice as a locum but who lacked knowledge of IT as well as keyboard skills (mediators) preventing uptake and use of the new system. Younger generations were more enthusiastic and engaging with IT resulting in different outcomes (simple intermediaries). The flexibility offered by ANT facilitated the examination of these different intermediaries which demonstrated different outcomes to similar implementing systems due to tracing contextual processes of translation and network-building which took place.

Thus, to summarise ANT, researchers focus their attention on symmetry between human and non-human objects, meaning precedence is given to neither in the social world. ANT places an emphasis on *Black Boxes*, making the assemblage of hidden networks visible. *Heterogeneous Engineering* is a way to trace these networks and *Translation* a practice to examine what actually occurs and what it means.

3.11. The Sociology of the Professions

Having clarified the merits of ANT and developed an awareness of its values as a theoretical tool, it is now necessary to introduce another theoretical framework; the sociology of the professions. How these additional conceptual tools relate to the forthcoming analysis of social care information creation and management are now explained. For instance, complex processes and power dynamics between and within different professionals are integral to social care data creation and management. The sociology of the professions is called upon to provide further a complementary examination of these forces at work. It is important to take the following elements into consideration which ANT pay little attention to social structures; professional authorities, bureaucracies, hierarchal structures and historical contexts during network tracing activities [252, 253].

The sociology of the professions is principally concerned with work and the division of labour and is an umbrella term for a range of theoretical views to explain the relationships both within and between different professional domains. The precise definition has long been problematic and much debated [254-257]. Many writings on the topic can be traced back to American sociologists Talcott Parsons (1902-1979) and Everett Hughes (1897-1983) who made significant contributions [255].

Traditionally, society inherited socially constructed 'professions' encompassing lawyers, clinicians, educators, high ranking military staff and religious orders [258]. They were distinguished from other occupations through numerous different criteria due to the historical nature of being perceived as the privileged and elite of society. Their characteristics were described by Freidson and others as boasting a more specialist learned body of knowledge, highly remunerated, self-governing and held in high esteem by society through serving the needs of the public [255, 259, 260]. Abbott and Meerabeau argued 'no occupation calling itself a profession can meet all of these criteria' [256 p. 4].

Never-the-less, professions developed powerful committees to maintain social boundaries through monopolising and regulating the labour market [256].

Critics have increasingly viewed the traditional notion of professions described above as outdated due to technological advances in the modern era bringing new and malleable occupations of equal complexity and expert fields, altering the division of labour [261]. As an example, Dingwall demonstrates the journey of a health visitor from obscurity to emergence and subsequent official recognition in the labour market as a post graduate qualification to a nursing degree, arguably a profession [261]. Whilst a provocative case can be contended around differences in definition (and many have), the purpose of this section is not to delve into this still un-resolved matter. As Freidson suggests, there are many legitimate viewpoints but that they are unlikely to lead to a universally accepted definition of the word 'profession' that will prove of any overall analytical worth [255].

Many sociologists have since shifted from attempting to define characteristics to analysing professional strategies. In other words, examining steps taken by groups already recognised as professions as well as those aspiring to be recognised as professionals by exploring motivation and power influences of hierarchy. [256]. As a consequence, Freidson recommends the following:

> *'I feel that serious writers on the topic should be obliged to display to readers what they have in mind when the word is used – that is, to indicate the definition upon which their exposition is predicated and, for even greater clarity, examples of the occupations they mean to include and those they mean to exclude'* [255 p.35].

This study thus views 'profession' by describing what an occupational group does, what specialist knowledge they claim to hold, how they interconnect with other groups and what strategies are enacted, rather than classify into a conventional 'profession' perspective. Therefore, any person belonging to social work, health care, technology or administrative groups who interact with the sociotechnical networks under observation will be the main focus.

3.12. Professional Dominance

Health and social care services are delivered by a wide-range of clinical, nursing, administrative, technical and social work staff. Each profession holds its own identity and hierarchal position where divisions can be distinguished not only across professions but also within each discipline [255, 262]. Key concepts that enable examination of the interplay between and within such professions can be found in the work of medical sociologist Eliot Freidson. Freidson developed an influential structural concept during 1970s where the medical profession controlled its own work force and that of other occupational groups through the premise of holding expert knowledge, termed professional dominance [263]. Knowledge was viewed as a source of power that afforded privileges, exclusive rights and control of domains to rule the division of labour.

From a social care data process perspective, it is important to pay attention to wider understandings of historical structural settings which influence present day actions and behaviours of specific occupations. For instance, social workers interact with a variety of professional groups during the course of their routine duties, gathering client information both internal and external to their domain. Professional dominance theory offers the potential to examine these inter and intra-professional relationships of high and low status staff and to make sense of the complex organisational structures of social care data processes.

Different hierarchies and bureaucracies of social order between and within health and social care can influence data collection and management. The consequences of which can affect client/patient outcomes through the distribution of resources and provision of services [263]. Access to care when the co-ordination of services are met by more than one profession can be problematic because of barriers created between professional domains. Whilst many studies have investigated clinician-nurse-administrator relationships [54, 264-269], studying specific hierarchal and bureaucratic interplays between health *and* social care staff during social care data collection in community and acute settings has not been examined to date. Similarly, there is a shortage of research which examines interplays between social workers and the supporting staff they work alongside. Therefore, if we are to understand the challenges and opportunities health and social care integration presents, a greater understanding of these concepts and relationships is required.

3.13. Boundary Work

Whilst Freidson's professional dominance was well established as a key theoretical framework in healthcare studies during the 1970s and 1980s, more recent writings argue that the concept is not entirely appropriate as a means to study intra and inter-professional relationships in contemporary healthcare settings [266, 267]. What is often contested is that professional dominance arguments do not pay sufficient attention to the dynamic nature of inter-professional relations as roles continually change. For example, modern healthcare has developed (and continues to do so) through the expansion of specialist nursing skill sets traditionally performed by doctors [267]. Additionally, ward routines were restructured meaning nurses were responsible for assigned patients leading to greater contact time and knowledge of individual health and social situations relative to ward doctors. Direct communication between nursing staff and medics has been enabled by the removal of the traditional ward sister channel and the introduction of the more inclusive MDT meetings. These new structures have empowered nurses to challenge or negotiate medical authority and judgements. The growth in person-centred care also presents challenges to professional power [270]. Despite these continual changes in task complexities, what often remains a constant is the fundamentally hierarchical relationship between professions.

These dynamics have led to modifications of Freidson's concept [266, 267]. For example, demarcation is a process that creates borders or limits around a profession, differentiating what can and cannot be performed by specific occupations through knowledge and skill, also termed boundary work [271, 272]. Boundary-making was conceptualised by Strauss *et al* as 'negotiated order' [262 p. 147]. Strauss investigated the division of labour based on his research in two psychiatric hospitals [262]. He suggested different occupations incorporating different training, status and ideology worked alongside each other and created patterned order through a continuous and complex negotiation processes.

Routines and work arrangements were established through explicit and tacit compromise, bargaining and mediation around formal rules and structures. Strauss argued these fluid micro-level negotiations (negotiation contexts) were facilitated as well as limited by macro-level (structural context), and that the former was key to shaping organisational order [262, 269]. For example, during his observations it was noticed that ward rules were informally modified, agreed upon and enforced for a period of time.

These adaptations would become embedded in practice but would then be reconstructed or re-negotiated during changes in organisations, operational procedures or when permanent staff moved away [262]. More recently, Grant and Guthrie observed and described these demarcation strategies being performed between GPs and administrative staff when examining safety practices of routine work in high volume blood test results [269].

According to Gieryn, when professions experience uncertainties or strains, boundary work intensifies whether aiming to expand, monopolise or protect respective disciplines[5] [271]. Roles and responsibilities can therefore come under threat from other domains pressurising existing ways of working. Strauss offered the negotiated model as being suited to studying other kinds of organisational settings that are large or complex, characteristics of which can include one or more of the following:

> *'(1) utilizes personnel trained in several different occupations, or (2) if each contains an occupational group including individuals trained in different traditions, then (3) they are likely to possess somewhat different occupational philosophies, emphasising somewhat different values; then also (4) if at least some personnel are professionals, the latter are likely to be pursuing careers that render them mobile – that is carrying them into and out of the organisation.'* [262 p. 168].

Given current challenges faced by health and social care services and the opportunities health and social care integration may offer, examining boundary work can help inform the distribution of labour when gathering and managing social care information in all its contextual and diverse permutations. For example, social workers form an integral part of patient discharge processes in acute and community hospital settings, and play a pivotal role in local community environments. Staff collaborate with a wide range of clinical, administrative and technical teams alongside clients, carers and family members. These between and across discipline interactions as well as the relationships

[5] Gieryn describes three aims: '(a) when the goal is expansion of authority or expertise into domains claimed by other professions or occupations. (b) When the goal is monopolization of professional authority and resources, boundary-work excludes rivals from within by defining them as outsiders with labels such as "pseudo," "deviant," or "amateur". (c) When the goal is protection of autonomy over professional activities, boundary-work exempts members from responsibility for consequences of their work by putting the blame on scapegoats from outside.' [258 p.792]

they develop with lay people include a variety of high and low status actors. Exploring Strauss's negotiated order; temporary construction and re-construction of patterned order during inter and intra-professional tasks whilst each hold different values and practices add further sector dimensions to this complex whole. The concept of boundary work using Strauss's approach and Gieryn's insights is therefore an effective framework to explore social order relationships [262, 271].

3.14. Identity, Roles and Responsibilities

Professional identity is a concept where individuals associate with attitudes, values and beliefs of a professional group, and where they compare and differentiate their profession from other professional groups [273-276]. Declaring an allegiance to a specific group also permits the exclusion of others who do not hold the same ethos and values. Boundary work can help explain the construction of professional identity [277, 278]. For example, Håland's study illustrated quite nicely how doctors were previously responsible for completing a patient record. However, on the introduction of the electronic patient record (EPR) this role changed giving nurses the right and onus to perform the task, indicating a greater recognition of their knowledge and skill and so expanding their professional identity [277]. Professional identity, roles and responsibility are influenced by what Fournier described as the 'logic of the market' where economic, political, cultural and technological trends or changes impact professional status [272]. Professional identity is ultimately impacted by the adjustment of roles and responsibilities afforded to those occupations and is therefore malleable in changing conditions. Thus with rapid changes to the health and social care landscape different professional identities are likely to benefit as well as lose in the sphere of perceived competence.

3.15. Research Questions

Based on the overall aims and objectives, the project will address the following specific research questions:

1. What factors affect the collection and management of social care data in integrated services for older adults?
2. How are professional boundaries negotiated between social care and health staff in integrated care settings as they collect and manage data?
3. What is the value of ANT for exploring data processes in practice?
4. How might data collection processes be improved in integrated care settings?

3.16. Summary

This discussion focused on the aims, methodology and theoretical framework adopted in order to guide and consider the collection processes and management of social care data. Key concepts of ethnography, ANT and the Sociology of the Professions have been critically reviewed placing an emphasis towards how each concept can assist in order to answer the research questions. Whilst ANT is a valuable toolkit for network tracing activity, the sociology of the professions incorporating professional dominance and negotiated order theory were introduced to expand our understanding of professional authorities, bureaucracies, hierarchal structures and historical contexts. The next chapter will describe the tools and techniques used to carry out this research.

4. CHAPTER 4. METHODS

4.1. Introduction

Chapter 3 focused on the study aims, rationale for and design of an ethnographic study to investigate how social care data are created, processed and managed. The chapter highlighted key concepts of ethnography, ANT and the sociology of the professions as the theoretical framework adopted. This chapter now describes the methods applied to conduct the research, including site and participant sampling, data collection and management, concluding with ethical considerations and analysis procedures.

4.2. Multiple-site Ethnography

Fields of inquiry in ethnography can take many forms. For instance, the traditional view directs efforts at a single site location to view the social world often referred to as a complex macro structure. More contemporary ethnography can encompass one department across multiple-site organisations. Other configurations can include many institutions confined to either a small or large spatial area and depicts the evolution of practice in modern ethnography as highlighted by Huby and colleagues [49, 51].

A multiple-site ethnography was selected in order to explore routinely collected social care information processes and practices. Collecting data from several sites allowed local contextual issues to emerge as well as provide an overall description and comparison of processes across regions. This is often depicted as macro and micro orders of social organisation [279]. Since no evaluation of social care data had been conducted to date from a Scotland perspective at the time of writing, a multiple-site approach was considered particularly pertinent to the research aims. Obtaining views and experiences from more than one district offered an opportunity to take a regional not just local view of opinions and experiences. A broader range of differing views therefore, offers a more expansive assessment of similarities and differences across settings [280].

4.2.1. Data Triangulation

The ethnographic approach applied to this study involved non-participation observation, semi-structured interviews, field notes and documentary analysis. Collecting

information from different sources is termed ‘data triangulation’ and accredited to Denzin in 1970 [281 p.310]. Combining data in this way can serve to test or check one source of information against another, increasing credibility and confidence in the research interpretation [196, 282]. When applying this complementary rationale it seemed reasonable to assume that observations would help facilitate a deeper and corroborative understanding of data processes and practices to complement interviews [283]. Interviews can also be used to clarify anomalies detected during observations and other interviews. Field notes and documentary analysis enhanced participant data helping to provide a solid base for the final analysis and subsequent report of the ethnography.

4.2.2. Site Sampling

From 32 local authorities in Scotland, three council districts were recruited to create individual ‘case studies’ [208 p.15]. Case studies are described by Yin as a detailed analysis of a person, a group, an situation, or an organisation and therefore considered relevant to a social care configuration [208]. Multiple case studies were then combined to portray a set of ‘cross-case’ interpretations and assumptions [208 p.18]. The general idea here is to build an overall explanation that fits all cases, despite the fact each would contrast in certain aspects. This was exemplified in a large multi-site study conducted by Martha Derthick which examined the failure of federal surplus land housing developments in diverse U.S. States. Derthick was able to describe parallels in each State to justify general conclusions even though each State experienced many local differences [208]. Closer to home, Crow and colleagues present a variety of case studies and investigate the value of single and multiple case projects in health-related studies. A multiple site study offers a more collective, broader appreciation of a phenomenon of interest and thus in terms of social care information processes can maximise what we can learn from this thicker type of enquiry [51].

Sites which had the potential to offer a wide range in terms of geography, organisation size, configuration and client group were identified and approached via key contacts within health and social care services. Approval was obtained from each local council and also their associated health board. The study acknowledged that social care workers operate from acute and community hospitals as well as within local community environments and as such observations and interviews would likely take place on NHS premises and involve NHS patients. NHS approval was therefore necessary. NHS

research ethical approval was granted from the East of Scotland Research Ethics Service on 9th October, 2015 (15/ES/0117) (appendix 1).

Of the three districts selected, one involved a stand-alone city council, another encompassed one city with other towns and surrounding villages, and the remaining district council comprised towns and surrounding villages only. Populations levels in each district were fairly similar however, the geography of each district varied extensively in size and also from flatland to mountainous regions and urban to rural. Similarly, demographic features, both present and historic also differed offering a wide range of citizen groups and economic conditions. Table 1 shows the geography and demographics from each district [284, 285].

Table 1. Geography and demographic details for each council district [284, 285] .

Site	Population (to nearest 1000)	Size (Km^2)	% Population over 65 years	% Population SIMD 1*	% Population SIMD 10*
1	147,000	60	16.7	20	7
2	116,000	2,182	19.9	2	4
3	147,000	5,286	20.2	1	8

* Scottish Index of Multiple Deprivation (SIMD): Decile SIMD 1 = most deprived. SIMD 10 = Least Deprived (285).

4.2.3. Participant Sampling

Participant sampling followed ethical guidelines in accordance with the principles of Good Clinical Practice [286]. These guidelines are normally reserved for clinical research purposes however, since NHS patients were likely to be involved in the study, it was deemed appropriate to adhere to these values. Potential participants were identified and invited to become involved through key contacts and gatekeepers at each site. Details of interested personnel were forwarded to the researcher by email, telephone or in person. A study information sheet was then provided, created in three different formats to correspond with Interviews, Observations, Clients/family members (appendices 2a, 2b, 2c) and consent forms (appendices 3a, 3b, 3c) in order that potential participants could make an informed decision about taking part. Participants were given approximately two weeks to consider their decision at which time they were contacted either through e-mail or telephone to learn their choice. Once satisfied that they were happy to continue,

mutually convenient arrangements were made to begin the observation period or conduct the interview.

4.2.3.1. *Purposive Sampling*

Recruitment began as purposive sampling in the first instance supplemented by snowball sampling, (see section 4.2.3.2.) but remained flexible to enrol additional participants from relevant groups if saturation of data had not been reached [196]. Saturation is where no new topics or ideas emerge [50, 196, 197, 287]. To keep abreast of what was considered saturation a topic guide was created as a prompt and reference point which captured the essence of the investigation (appendix 4). Although originally produced to present to participants in advance of interviews, the guide was useful during observation periods to keep track of the type of information accrued and also to gauge what was still to be acquired.

Recruitment incorporated participant diversity in age, gender and ethnicity as much as situations would allow with participants holding key knowledge, experience and views to provide as heterogeneous a study population as possible. For example, social work traditionally employs more female staff than male therefore there was a gender imbalance with front line social work and administrative participants. Equally, with regards to different professional roles, there were more male data managers than female. Furthermore, some departments comprised mostly of people who had served in the same position for a number of years and were therefore of a more mature age rather that younger newly qualified staff found in other departments. Participants were never-the-less, reflective of respective organisations and professional roles.

4.2.3.2. *Snowball Sampling*

Snowball sampling was facilitated by initial interviews and observation periods. For instance, if a participant could not answer some questions, they would often suggest another colleague or department. Participants would often offer to contact them on behalf of the researcher and provide contact details if it transpired they were interested in taking part in the research. Snowball sampling was also conducted via more informal means. For instance, whilst sitting with various groups at staff break times in department canteens, or rest areas, some members would enquire about the study then offer themselves as participants if I felt they could be useful to the process. In this event an

information sheet and consent form were provided for their consideration before following through with a scheduled appointment to interview or observe.

4.2.4. Non-participation Observation

Observation periods were designed to capture real time processes of social care client information collecting and recording. Social workers operating at the front-line (i.e. gathering data directly from clients) were shadowed to explore how this occurred during a typical day and how this information was translated over time and space. Participants were asked to talk through tasks being performed and to explain why. A wide range of social workers with varying degrees of experiences and views operating from community localities and hospital settings took part. Observation periods began during February 2016 and ended in September 2017.

Over time, some relationships developed more strongly than others and these participants became key informants. For instance, every so often the researcher would telephone and ask for clarity on issues that seemed confusing or conflicting during other interviews or observations and without question, personnel were always happy to oblige. Explanations helped to piece together fragments of information which in turn helped forge a wider picture of order. This was reassuring and much appreciated given their already busy schedules.

4.2.4.1. *Sites*

Each social worker was observed for approximately one week beginning at their office base, watching how they carried out routine tasks. A typical day would vary but include visits in a client's own home, nursing and residential homes, or hospital settings. Other appointments included department team meetings, multidisciplinary team meetings (MDT's), case conferences and seminars and these varied from participant to participant. Timescale differences were determined by information garnered during the observation period and also by the nature of each social worker's practice diary. The ideal scenario was to observe each participant for an uninterrupted and consecutive period. However, some staff could not achieve this for personal or professional reasons which meant some observation periods were divided into separate time periods. An example of this drift from standard was due to staff sickness or the incidence of a social worker being called

away to an unplanned appointment where approval for the researcher's attendance was not pre-consented.

4.2.4.2. *Observation Process*

Observation periods allowed 'being there' and also provided the opportunity for informal discussions when appropriate, as a means to elaborate on some actions or to clarify any misunderstanding during activities. These discussions also helped to explain work flows, relationships and nuances between individuals as well identify similarities and differences between IT systems, departments and other agencies. Field notes were taken as and when appropriate as an aid to recall later in the evening when writing up. This was mostly achieved when accompanying the social worker when travelling by car from site to site or during other opportune moments. Due to the difficulties of writing comprehensive notes during car travel, notes were made by jotting bullet points in the field notebook which served as a reminder of an event, conversation or setting. When time permitted, these smidgeons were transferred into handwritten paragraphs during the day and then converted more comprehensively into typed versions during the evening back in the office. Considered the cornerstone of ethnographic methodology, Madden referred to the end-of-day notes as 'consolidated notes' when jottings, hand written paragraphs alongside reflexive accounts developed into thoroughly preserved moments of the enacted day [222 p.123]. Ultimately, field notes were messy in appearance; never-the-less they were full of substance and captured the essence of each action, conversation or setting resulting in meticulously date-timed chronicles. Notes were typed up diligently on the same day to ensure that loss of detail was minimised.

Notes were not taken during client home visits or when meeting a client in a care home or on a ward setting as this type of action may have altered the atmosphere and could perhaps have made the client feel uneasy. The researcher was also able to dedicate herself to active engagement without interruption, storing details in memory until immediately afterwards when notes were made. As a non-participatory researcher, this process also enabled the researcher to accompany the social worker as unobtrusively as possible without distracting the flow of actions.

With permission and where appropriate a digital audio recorder was also used to gain a sense of relations, language and natural workflow during conversations that social

workers had with other staff in the department or on the telephone. Particular attention was paid to when and where a request was made. For example, client assessments or MDT meetings on the wards were deemed inappropriate. Occasions where the recorder was normally used involved office space where small groups of staff worked together. If there was a sense that information from discussions had the potential to capture workflows, permission was requested to start the recorder in order to document the process. These recordings served as another aid when writing up. This outline is based on Savage, 2000 [50].

Additional documents were obtained (with permission) during observations to verify formal forms used in the pursuit of client information collection and recording processes. These included client assessment forms and also copies of procedures to perform financial assessments and other processes such as the guidelines for the transfer of patients from an acute setting to a social work hospital discharge team.

4.2.5. Semi-Structured Interviews

Semi-structured interviews were conducted to gather information from a range of professions and roles in accordance with guidelines from the literature [47, 196] Participants included executive, managerial, front-line staff, administrative and IT personnel who were involved with social care information. The overall emphasis was on obtaining a deep insight into social care data production and exploring how information was used and shared by staff and departments by as wide a range of personnel as possible. Data gathered would shed light on successes and challenges of client information collection, its development over time, and how this translated to use in different professional roles. Consideration was also given to participants' perspective in terms of personal beliefs and attitudes. Interviews began during January 2016 and ended in August 2017.

4.2.5.1. *Sites*

Sites involved varied in relation to local arrangements and preferences. Interviews were therefore arranged to meet site-specific needs and at a convenient time and place for participants. Some participants were interviewed in pre-booked rooms, particularly where hot-desking environments operated. Other interviews took place in participants'

own office. There were some instances, on a hospital ward for instance, where it was a case of finding a quiet space removed from the routine workings of the ward.

4.2.5.2. *Interview Process*

Participants were given a topic guide which included questions likely to be asked. These were sent by email or given by hand in advance of the interview so that participants had time to consider their responses (appendix 4). The topic guide included 28 questions divided between 7 broad themes. Not all questions were asked of each participant as some were not pertinent to all professional roles. Each interview lasted around 50 minutes although one was as short as 15 minutes and one as lengthy as 1 hour 59 minutes. The short interview occurred when enquiring about specific information following a previous interview. The longer interview revealed a host of pertinent information where the participant was happy to continue to divulge.

During most interviews and with permission, participants provided documents to verify their statements. These included artefacts such as maps showing boundary zones, spreadsheets listing delayed discharge records and other forms of policy documents to authenticate their comments which were of immense help during analyses. Documents and interviews helped strengthen the researcher's understanding of events occurring in the field and vice versa to offer a wider picture of data processes. Each interview was a unique experience and over time techniques were fine-tuned to accommodate different situations and environments. There is a skill in gaining a balance between keeping participants focused on questions in hand, allowing sufficient deviation to encompass individual experiences and beliefs, whilst at the same time without too much digression to the point of nothingness, a delicate consideration which continued throughout the study experience.

4.3. Data Generation and Management

4.3.1. Observations

Data were protected by observing stipulations of the Data Protection Act (1998) and this is discussed in more detail in the Ethical Issues section [(288)]. Field notes and digital recordings were typed up on a Microsoft Word© document each evening at the end of

each observed day. Field notes were instrumental in helping to prompt memory recall when it came to describing a person, conversation, setting, or process.

Documents were anonymised, transcribed verbatim and exported to NVivo 11© software programme for thematic coding, synthesising, data managing and analysis. Care was taken to make sure not just names of participants were removed from transcripts, but also other details which at the outset seemed banal, but in context could make a person or place identifiable. Issues such as street and office names, ward numbers and care home names, cities, towns and villages were coded with a unique 3 or 4-digit combination of letters and numbers to protect the identity of participants, co-workers, clients and their families. This included coding colloquial language of names and places and other idiosyncratic information which through their distinctiveness could reveal identity.

4.3.2. Interviews

Interview recordings were transcribed verbatim and anonymised on a Microsoft Word© document at the end of each interview. The same technique of applying a unique 3 or 4-digit letter and number combination as for field notes was applied to conceal identity of people and places. Transcripts were exported to NVivo 11© for thematic coding, synthesising, data management and analysis. A selection of interviews and observation transcripts were proof-read by the study supervisor to help ensure levels of content, accuracy and integrity were met.

4.4. Ethical Considerations

The study involved interviews and observation at a variety of NHS and local authority sites which required approval from each organisation. NHS Integrated Research Application System (IRAS) procedures were duly completed. Ethical approval was requested on 3rd July, 2015 and subsequently granted by the East of Scotland Research Ethics Service 9th October 2015 (15/ES/0117) (appendix 1). Each local authority was approached independently and permissions were granted in turn. The research followed the approach by Michael Angrosini and Judith Rosenberg who viewed participants not as subjects but as ‘active partners’ who understood the goals of the research and who helped develop and shape the research plan [289 p.467]. Therefore, at the outset and before

the research began, conversations were held with numerous social workers to get a sense of what could be portrayed as a typical day in a social worker's life.

After taking stock of scenarios likely to be experienced, account was then taken of ethical implications surrounding these. Whilst it was not possible to pre-empt every possible eventuality, the following contingencies were developed to protect the dignity and well-being of participants. These drew from one of the main ethical frameworks in healthcare research applying its four core principles that lie at the heart of moral and ethical reasoning: respect for autonomy, non-maleficence, beneficence and justice [286]. The main ethical issues related to consent, anonymity, confidentiality and data protection as follows:

4.4.1. Consent

4.4.1.1. *Participants*

Potential participants were each provided with an information sheet containing study specifics and an explicit consent form for endorsement (Appendices 2a, 2b, 2c. and 3a, 3b, 3c respectively). Additionally, informal discussions with those who expressed an interest in the study were organised which also offered the opportunity to build rapport and trust. It was the researcher's responsibility to ensure participants were fully informed to consent therefore, individuals were reminded that their participation was purely voluntary and they could decline or withdraw at any time without fear or explanation [286]. Consent was viewed as an ongoing process to take into consideration individual changes of personal or professional circumstances over the study period. One copy of the signed consent form was retained on file and another given to the participant.

It is important to emphasise that in terms of observations the focus was directed towards social workers and how they conducted their routine tasks. No personal data was collected from other people present. However, it was acknowledged that when conducting observations, service users, family members, council staff and other professionals may be present (i.e. client home or ward visits, professional meetings or shared office space) which warranted careful ethical consideration.

4.4.1.2. *Clients/Family Members*

Social workers visit clients and NHS patients as part of the assessment process or case review. In some instances, family members were likely to be present during the shadowing period. The success of the study was dependent upon access to these types of scenarios to allow the true context from which client information was obtained.

Once consent was obtained from relevant social workers, the researcher relied on the social worker to schedule home or ward visits. Social workers were asked to explain the study in advance to clients and other family members who were expected to be present. A study information sheet and consent form were provided for the social worker to pass on. If family members were not scheduled to be present, the social worker was asked to offer the opportunity to invite a supportive family member, friend or someone they trusted in order to reduce the potential risk of feeling outnumbered or uncomfortable during the observation. Verbal consent was sought from both the client and relative/friend/advocate in advance of the visit by the allocated social worker, in the first instance.

Once verbal consent was obtained by the allocated social worker, and the appointment confirmed, the researcher then explained the study again to clients/advocates on the day of the home or ward visit. Clients/advocates were asked to confirm consent after being given the opportunity to ask questions. One copy was kept on file and another given to clients/family members. Clients/family members were of course reminded that they had a choice in whether to participate or not. The researcher was guided by the professional view of the social worker regarding this alongside participant capacity to consent in the first instance. Ultimately, it was the researcher's responsibility to ensure capacity to freely consent. If there was any doubt about meaningful understanding upon arrival at a home or ward visit, the observation would not proceed.

Study details (information sheet and consent forms) were produced in simple language to aid understanding. There was a possibility that some clients held English as their second language which could have jeopardised fully informed consent. However, home and ward visits were planned by the social worker in advance following direct communication with clients. Therefore, knowledge of such cases were identified beforehand where social workers had a duty to consider the use of an interpreter.

4.4.1.3. *Co-workers*

Social workers attend MDT meetings and case conferences during the course of their routine work. These gatherings are normally attended by a range of professionals, and sometimes clients and family members, presided by a senior social worker, manager (community setting) or clinical consultant (hospital setting). In the event of this type of scenario, the allocated social worker discussed the study with the chairperson in advance. The chairperson was provided with a study information sheet they wished to read. Once verbal consent was obtained from the chairperson, he/she then assisted to introduce the study to members to gain verbal consent from attendees. In the event that consent was not agreed from each person present, the observation still proceeded, however any interaction the observee had with any objecting member was not gathered or documented. Clients/family members were informed using the protocol described in the previous section (4.4.1.2.).

4.4.1.4. *Professional Meeting/Seminar*

In the event that a social worker attended a professional meeting or seminar, study information was provided to the presiding member of the meeting in the same manner as described for case co-workers (4.4.1.3.). Verbal consent was obtained from each person present.

4.4.1.5. *Shared Office Space*

Some social workers did not have their own enclosed office space and instead operated in an agile, mobile or open working environment, which exposed co-workers to periods of observation. Although no data were collected from co-workers, such instances were identified as far as possible at the outset and the following actions were taken to protect autonomy.

Prior to observation periods taking place, each co-worker was identified as much as possible and the research was explained to them. Colleagues had an opportunity to ask questions prior to any observation. Verbal consent was obtained. If colleagues did not wish to consent, data were not collected during any interaction made between the colleague and the social worker under observation.

It became apparent that some clients, other professionals or members of the public might present impromptu. Posters were displayed on office doors and walls to inform unplanned visitors of study details. Where possible, they were advised that observations were being conducted and given a study information sheet to read. Verbal consent was sought. It is important to reiterate that the focus of attention was directed towards the observed social worker and not others present. If unscheduled visitors did not wish to consent, the observation continued but specific individuals who objected were not included in observations and no data (i.e. field notes) were gathered on their activities.

4.4.2. Data Protection

Information was managed by observing the stipulations of the Data Protection Act (1998) [(288)]. Data were fully anonymised by attaching a unique 3-4-digit combination of letters and numbers, cross-referenced against each audio-recorded interview, observation and field note. Resultant identifiable information was held separately in a password protected computer at the University of Dundee. Hard copy notes were stored in a secure cabinet within a locked office.

4.4.3. Confidentiality

Participants were informed about measures to protect confidentiality and that information provided by them would be fully anonymised to protect their identity. Any breach of this necessary value would only occur if disclosures were considered a threat to the self, others, or of an illegal tendency [(290)]. For example, the researcher had a duty to report any instances of dangerous, discriminatory or exploitative practice. Conversely, it was possible to be privy to derogatory comments, criticisms of colleagues or discussions of clients, and any such instances remained confidential. In relation to an occurrence of the former event, the first point of contact would be the researcher's supervisors where they would disclose details of the incident. The researcher would then be guided by their instructions as to whether the event warranted further involvement and also accept support regarding the most appropriate manner to carry this out if needed.

4.5. Researcher Role in Practice

Key to successful ethnography is having an awareness of what a researcher brings to a study in terms of assumptions and biases from personal and professional life experiences. Through reflexivity, the constant questioning of beliefs and attitudes helps to act as a bridge to how data were captured and interpreted. For this study, the researcher felt particularly suited in terms of any preconceptions she may have acquired, since she was neither social work nor health care in professional background. Her predominantly business acumen meant that she was a neutral outsider with an insider interest. This stance was found to work to her advantage when conveying her layperson view of each organisation to participants. Consequently, participants viewed her as having no allegiance to any specific position other than in pursuit of finding out as much as she could about how social care information materialised from all viewpoints.

Before beginning interviews or observation periods, the researcher met, or talked on the telephone with each participant to build rapport and also to assure some who may have felt the process was intrusive or who were uneasy about being recorded or observed. Once a comfortable level of mutual communication had been nurtured (but still maintaining a distance), interviews or observations commenced. The researcher occupied their territory of knowledge, their office space, and their time; subsequently, any potential anxieties they may have envisaged were soon dispelled.

As Watts points out, not only does a researcher bring their own beliefs and attitudes to a project, but also their emotions [(291)]. There was a great sense of sadness when witnessing some clients living in poor conditions with the barest of essentials and nothing in the way of noticeable comforts. An inordinate amount of time was spent re-living those visits where initially it was difficult to accept the reality, regularly holding an inner dialogue of ‘how can this happen’. For some clients it was a lifestyle choice, for others it was the embarrassment and delay in admitting they needed help, whilst a number were just plain fearful at the prospect of moving to a care home. There was a recognition that these people were fortunate, at least in the sense that they were now under the radar of care and support and accepting of help. ‘What about those off grid?’ was the next mantra that seemed to re-play time and time again. Through further reflection and discussions with the research supervisor a default position was adopted for the purpose of the study in that ‘it is what it is’ so as to remain faithful to the ethnography. Besides, the very fact

that the matter was being studied gave some small comfort in the knowledge that at least these situations were being brought to light with hope that some good might be achieved as a result.

4.6. The Best Laid Plans

The original research plan involved the co-operation of three different health boards incorporating six district councils. Keen interest was expressed by all nine bodies at the outset. Each health board formally committed to the study through the Integrated Research Approval System (IRAS) process. However, of the six district councils only three were able to officially pledge their time. A combination of new staff appointments, health and social care integration going live during April 2016, plus general work pressures, led to three having to renege at the eleventh hour. The study was subsequently pared back as discussed above. The disappointment of losing the remaining district councils serves as a reminder that research in the real world can often throw some curved balls. It is always prudent to be prepared for the unexpected and consider potential adjustments throughout the design and protocol stages to ensure a viable outcome. As it transpired, the remaining councils willing to proceed were sufficient in size and variation to provide a between and across comparison ethnography, although the news of withdrawal was disheartening at the outset.

4.7. Data Analysis

In keeping with the methodological section, analysis proceeded interpretively and in parallel with ongoing interviews and observations as follows [47, 196, 292].

4.7.1. Coding

Coding was accomplished firstly by importing transcripts into NVivo 11©, then reading each in turn to encapsulate the entire field experience as it evolved over time, described as 'close reading' in the literature [292 p.171]. The researcher took stock of each sentence, and asked 'what is this statement saying' in order to code, or attribute a node in NVivo©. So for example, if a sentence talked about IT systems, a node 'IT Systems' was created and allocated against the statement. Similarly, if a sentence mentioned professional roles the same process applied, and so on. Some statements talked about matters that over-

lapped with other nodes, in which case each node they referred to was highlighted. For example, some sentences related to IT systems which also linked to organisational procedures in which case the statement was attributed alongside both nodes. This is what Emerson and colleagues call 'open coding' reflecting events and experiences that develop into ideas and themes [292 p.175].

When open coding was complete, transcripts were then re-read; looking again at each sentence in turn and assigning statements in a more fine-tuned manner to further clarify developing thoughts and themes for the final ethnography. This inductive and deductive process is known as 'focused coding' [292 p.191]. Initially, nodes were created that related to the three key concepts of ANT: Black-Boxes/Punctualisation; Heterogeneous Engineering; Translation. Through further background reading an additional four nodes emerged taking a deeper insight to ANT as the coding progressed, for example, failing networks, legitimisation and reciprocal delegation. Similarly, nodes were developed from the sociology of the profession models. This procedure condensed nodes to provide themes and sub-themes. Madden describes this as 'shifting the process from analysis to interpretation.' [222 p.152]

During this process additional ideas would occur to the coder. When this occurred and in order to continue coding in an attentive manner, the memo function on NVivo 11© was found to be useful to record these insights which served as a diary for further concepts. During the entire practice there were many re-arrangements and re-attributing of nodes. Thoughts were centered around core topics that helped answer the research question without being rigidly committed to one process or order of analysing [292]. For example, during client visits to residential or nursing homes, many field notes described living conditions. Variations in cleanliness, ambience, facilities, location, and staff were found to be intriguing and somewhat transfixing. However, after much reflection the examination of urine smell levels versus quality of care, no matter how interesting (and important) would not contribute to understanding data collection, processes and management. This is what Emerson and colleagues describe as a means to identify a set of core themes from a large set of data [292].

4.7.2. Interpreting Data

When focused coding was complete, query builders were formulated. This is a process in Nvivo 11© which helps find associations with different nodes and themes. The query builder function also incorporates the memo feature into the analysis when searching for links, which was particularly useful. Here associations were queried between the key concepts and sub-concepts of ANT and the Sociology of the Professions along with nodes from broad themes of focused coding. Each association was read meticulously as a means to 're-viewing, re-experiencing and re-examining' everything before forming the basis for reporting the ethnography [292 p.173]. Analysis was supplemented by documents collected throughout the research process in order to support findings and also to provide further insight. Referral and assessment forms, maps, brochures, local authority guidance notes and seminar hand-outs were reviewed in turn and manually catalogued into site and date order to compare across respective themes and organisations (Table 4).

4.8. Overview of Data Generation and Management

A variety of data sources were collected across three diverse local authorities and NHS sites. Data included interview transcripts, observational field notes alongside supplementary documents to support data from 29 participants. A total of 13 interviews were conducted comprising executives, service managers, administrators and data strategists/managers, resulting in almost 14 hours of digital recording (Table 2). Interview length and topics varied and were dependent upon profession and role. For example, junior administrators were not typically asked questions relating to data linkage as these types of questions were outside the remit of their role and knowledge. Additionally, data managers were not requested to share their views on local authority assessment processes, bearing in mind their unfamiliarity. Clarification of some transcripts were required and was achieved by contacting participants directly via email, telephone and sometimes in person. For instance, some members of staff used terminology that suggested a similar role or process previously reported but a different narrative was presented (i.e. a care assessor and support worker are terms used by different local authorities but represent identical roles and responsibilities). These were queried as soon as possible after the event to offer a clearer understanding and more accurate meaning.

Table 2. Interview participant and transcription details. Specific job titles are withheld to protect anonymity.

Interviews				
Site Number	Participant Number	Appointment	Time in mins (hours)	Transcribed Word Count
1	A101	Social Services Manager	63	10,641
1	A103	Social Services Manager	55	6,649
1	A104	Data Manager	57	7,645
1	A106	Administrative Manager	65	10,181
1	A108	Social Services Manager	61	9,558
1	A110	Administrator	15	1,478
1	A111	Data Manager	44	7,825
2	B201	Administrator	50	5,542
2	B202	Administrator	43	4,501
2	B205	Data Manager	119	21,953
3	C301	Data Manager	116	16,916
3	C302	Social Services Manager	62	8,517
3	C303	Data Manager	59	8,614
Total	**13**		**809 (13.4hrs)**	**120,020**

Over 370 hours of observational data from 16 participants accrued 86 pages of field notes. These derived from an assortment of care managers and care assessors of different age groups, levels of experience and time in service operating at the front line (Table 3). Individual observation periods varied from 1 to 7 days (1 day ≈ 7 hours), and although some deviation from the scheduled 5 days was projected, some instances resulted in observing for just 1 day. This was mainly due to unforeseen sickness leave or other local work commitments where my consent to attend was not previously obtained. During these events, co-workers stepped into the breach to help the research process. These volunteers however, could offer limited time periods at such short notice i.e. 1 day. Observation was however, sufficient to maintain engagement with all aspects of data processes in localities since emersion took place in the same office occupied by the absent social worker under observation.

Table 3. Observation participant and transcript details. All Participants were front line social workers.

Observations				
Site Number	Participant Number	Observation Period in days (hours)	Field Notes in pages	Field Notes Transcribed word count
1	A102	7 (49)	15	10,379
1	A105	5 (35)	9	8,553
1	A107	4 (28)	3	4,910
1	A109	5 (35)	4	8,047
2	B203	4 (28)	9	7,941
2	B204	2 (14)	2	905
2	B206	6 (42)	9	8,363
2	B207	1 (7)	2	701
2	B208	1 (7)	1	757
2	B209	1 (7)	1	602
3	C304	4 (28)	7	5,282
3	C305	3 (21)	7	3,016
3	C306	1 (7)	1	430
3	C307	3 (21)	3	1,189
3	C308	2 (14)	3	3,467
3	C309	1 (7)	4	4,632
1	Revisit Site 1	1 (7)	1	631
2	Revisit Site 2	1 (7)	2	1,951
3	Revisit Site 3	1 (7)	3	1,211
Total	**16**	**53 (371)**	**86**	**72,967**

An additional 96 documents were collected during interviews and observation periods (Table 4). These materials were diverse in nature, but essentially included day to day forms used by social workers alongside policy and guideline documents. Different terminology was used by different local authorities to describe forms designed to capture identical information. Articles were catalogued in the format they were received to offer a sense of variation and language used. For example, some local authorities used the term ‘Outcomes Focused’ whilst others made use of the expression ‘Self Directed Support’ or ‘Single Shared Assessment’ when referring to the assessment process. Similarly, when applying for a care package a variety of terms were adopted; ‘Funding Request for Plan Form’ and ‘Personal Care Support Request’. Columns where more than one document was represented is signified by the number of different versions obtained.

Table 4. Study supporting documents characteristics.

Document Description	Site 1	Site 2	Site 3
Adult Respite Request Guidance	✔		
Adult Support and Protection Guidance	✔		
Assessment of Services Summary Details	✔		
Care Home Funding Recommendation/Report Form	✔ 2		
Care Home Vacancies Output	✔		
Care Support Funding Agreement	✔		
Client Consent Form	✔	✔	✔
Client Information Amendment Forms 1 and 2		✔	
Communication Documents to Support IT Failings		✔	
Community Alarm Referral Form		✔	
Community Care Needs List	✔		
Contact/Referral Details			✔
Data Quality Output			✔
Delayed Discharge Codes	✔		
Delayed Discharge Output	✔		
Eligibility Criteria Booklet/ Waiting Times Social Care Guidance Notes	✔		✔
Enablement Assessment		✔	
Enhanced Community Support Evaluation Framework		✔	
Free Personal Care/Nursing/Residential/ Financial Guidelines	✔		
Funding Request Form Crisis, Interim, Step-up to Temporary Residential/Nursing or EMI			✔
Handouts from Seminars/Meetings	✔ 2	✔ 3	✔ 3
Health Categories (Illnesses)			✔
Home Care Provision Weekly Return	✔		
Hospital Admission/Discharge Framework		✔	
Hospital Community Referral Procedures Flowchart (Unknown and Known to Community Teams)	✔	✔	✔
Hospital Discharge Referral Form: to Social Work/District Nurse Teams for Assessment/Screening	✔ 3	✔	✔
Hospital Pathways MFE	✔	✔	✔
Hospital Patient Discharge Guide and Flowchart	✔		✔
Hospital Patient Levels and Types of Assessments Guide	✔	✔	✔
Hospital Patient Referrals to Discharge Teams Procedures	✔	✔	✔
Housing Support Agency Referral Form	✔	✔	
Indicator of Relative Need (IoRN)	✔		✔
Initial Referral Form (community)		✔	
Learning Disability Statistics Scotland Guidance Notes for Government Returns	✔		
Map of Boundaries	✔	✔	✔
Medical Conditions List			✔
Outcomes Focused/Self Directed Support Assessment Form	✔ 4	✔ 3	✔ 3
Outcomes Focused/Self Directed Support Personal Outcomes Plan Form	✔		✔
Outcomes Focused/Self Directed Support Review form	✔		✔
Outcomes Star Measurement Development	✔		
Out of Hours Service Operating Hours/Contact Details	✔	✔	
Personal Care Support Request		✔	
Post Registration and Learning Guidance Notes for Social Workers		✔	
Process of Assessment and Care Management Guide	✔		
Resource Allocation Group Memorandum (Funding Request Permanent Residential/Nursing/EMI)			✔
Resource Allocation Output	✔		
Resource Allocation of Social Care Hours Meeting Guidance	✔		
Respite Statistical Return	✔		
Risk, Definition of Risk/Priority Factors Guidance	✔		
Self-Directed Support (SDS) Funding Request for Plan Form			✔
Self-Directed Support (SDS) Options			✔
Social Care Returns Forms (Scottish Government)	✔		
Social Care Returns (Scottish Government Guidelines)	✔		
Technology Enabled Care Solutions: Examples			✔
Third Sector information leaflet		✔	
Transfer/Increase of Funding Recommendation	✔		
Total	**44**	**25**	**27**

Open and focused coding (see section 4.7.1.) resulted in over 4,000 references where patterns emerged once query builders were performed on Nvivo. Associations were examined between themes from focused coded data (n=59) with topics from ANT (n=14) and the Sociology of Professions (n=15). Synthesised data produced 4 broad themes; Data Collection Processes, IT Systems, Organisational Structures, Intra and Inter-professional Relationships. Table 5 shows main themes and subthemes from focused coding and Table 6 shows ANT and the Sociology of Professions topics.

Analysis was performed on a site by site basis however, for ease of flow and understanding, the order of reporting takes an overall view of field sites and highlights thematic similarities and differences between and across regions. Quotations from interviews and extracts from fieldnotes are identified by applying 'Interview' and 'Fieldnote' respectively before the site, participant number, appointment, and date of quote or extract. For example, '*Interview, Site 2, P201, Administrator, Tuesday, 08/08/2017'* or '*Fieldnote, Site 1, P107, Social Worker, Thursday, 29/08/2017*. Appointments are restricted to five fields to protect anonymity; social services manager, social worker, administrative manager, administrator and finally data manager. Other coded information such as names, places and so on are explained as they are presented.

Table 5. Themes to understand social care data processes and management.

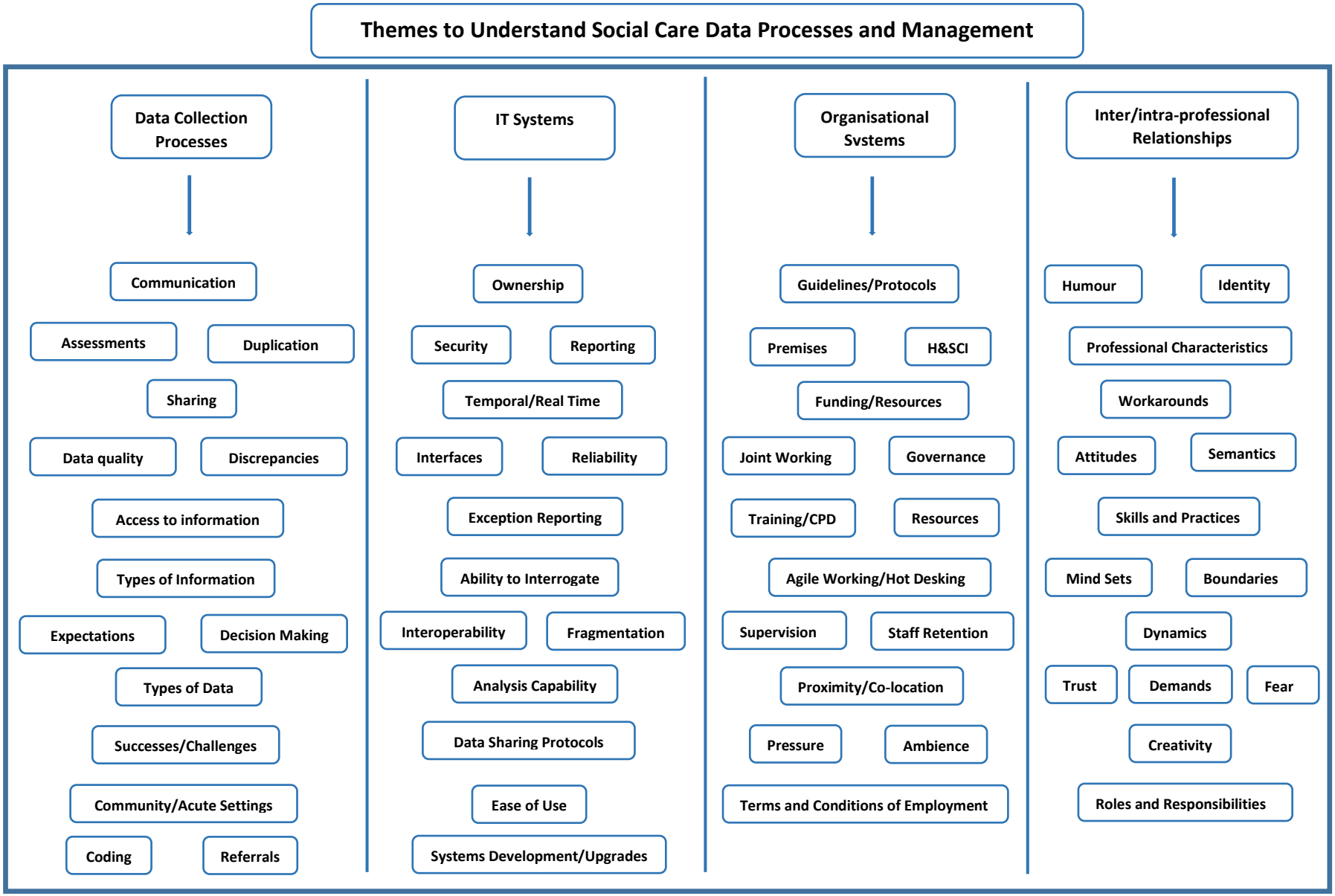
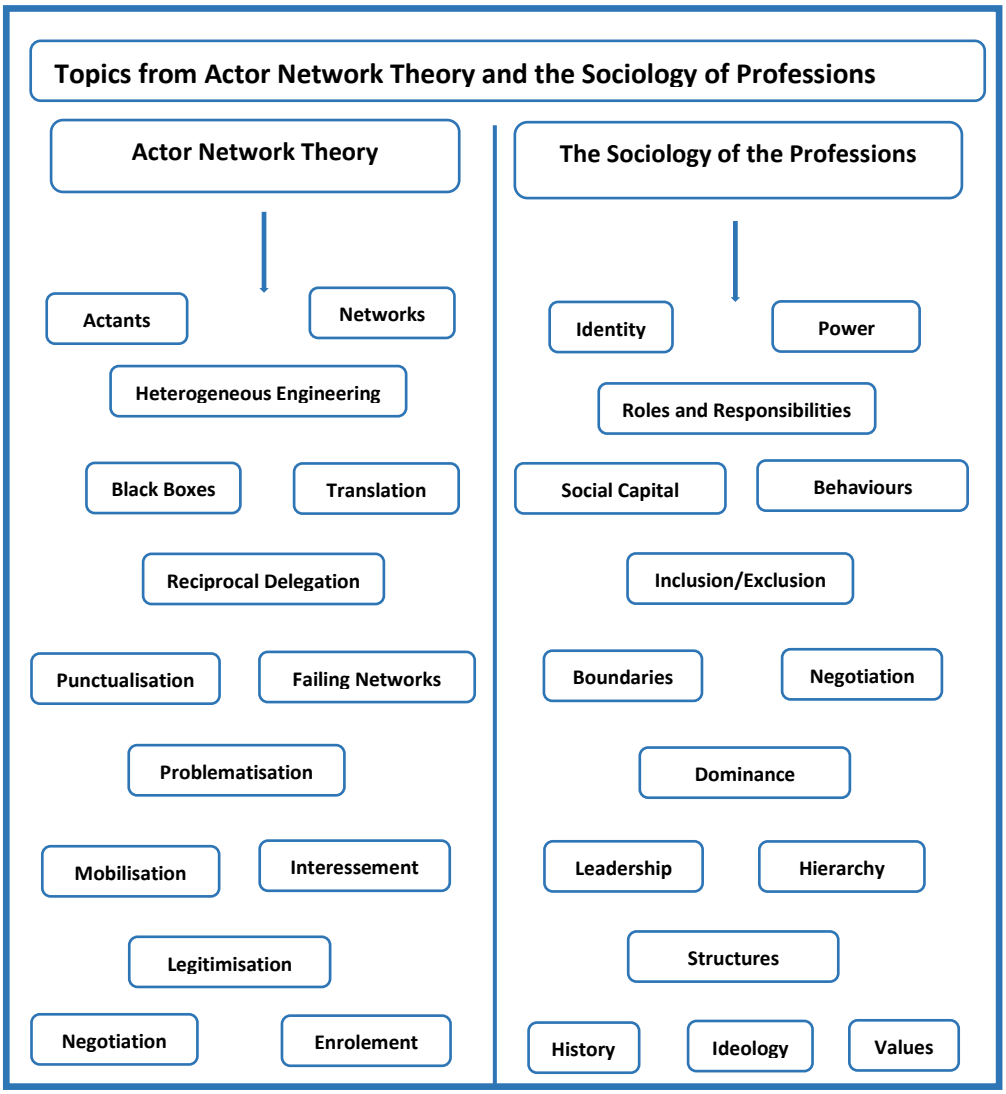


Table 6. Topics from ANT and the Sociology of the Professions.



4.9. Summary

A comprehensive account of procedures has been provided to clarify each stage of the research process. A multiple-site ethnography coupled with data triangulation was adopted to best explore macro and micro orders of the social organisation of social care information. A wide-range of professionals participated offering an all-encompassing view of social care data processes from executive level to data managers, administrative staff and front-line service workers. Every step of the research process was carefully considered with a view of pre-empting likely scenarios in order to inform and protect participants as much as possible. Data collection, coding and interpreting procedures were explained in a manner to provide a transparent basis for the analysis chapters.

Results from analyses are now reported to shed light on how social care data are created, processed and managed within and across these multiple field sites.

5. CHAPTER 5. OVERVIEW OF FINDINGS FROM THEME 1 – ROUTINE DATA COLLECTION BY SOCIAL CARE STAFF

5.1. Introduction

The previous chapter explained how the research was conducted taking into account ethical, pragmatic and analytical considerations including a presentation of overall data collected across the three fields under study. This chapter presents the results from the first of four overarching themes that emerged from analysis; Data Collection Processes; as described and enacted by social care staff during interviews and non-participation observation. The theme 'Data Collection Processes' is divided into two chapters to provide a more fine-tuned structure to this large section of data. First, this chapter portrays an overview of everyday data collection practices in order to unravel multiple tasks performed by social care front line and administrative staff. The report follows clients' care journeys from initial referral to assessment, provision of services and ongoing data collection. The second chapter (chapter 6) draws attention to key factors that influenced the gathering and management of these data.

5.2. Data Collection Processes

5.2.1. Initial Data Collection

A referral to social work can be submitted by a variety of people; by GPs, district nurses, community mental health teams, other AHPs, hospital staff and also by individuals, their families or carers. These can arrive through a wide range of sources; i.e. telephone, internal/external mail, fax, email, hand delivery and sometimes through word of mouth. Record keeping in the first instance is normally carried out by what is known as the First Contact Team, also known in some councils as the Access Team (community based) and the Hospital Discharge Team (acute or community hospital setting).

Respective teams check their data management system to establish if a client is already known to social services when a referral is received. Personal details are entered into the local authority IT system and matches are cross-checked using name and date of birth for accuracy. Of the three local authorities studied, two employed different off-the-shelf core case information and management systems (incorporating local enhancements and additional technology) and the remaining authority operated a locally developed in-house bespoke system.

Once the social work department determined the history of a client, the referral was passed to the team responsible for existing care. If the client was new to the system, First Contact or the Hospital Discharge Team created a new account and allocated a care team according to location and passed the referral to the appropriate care team manager. The system automatically created a unique reference number (URN) to which personal data were uploaded. Some local authorities and NHS establishments processed the passing of a referral to a care team manager by hand whilst others delivered electronically, by mail, fax or by courier. Figure 8 shows this basic process which is the same across all three field sites, although systems and details vary.

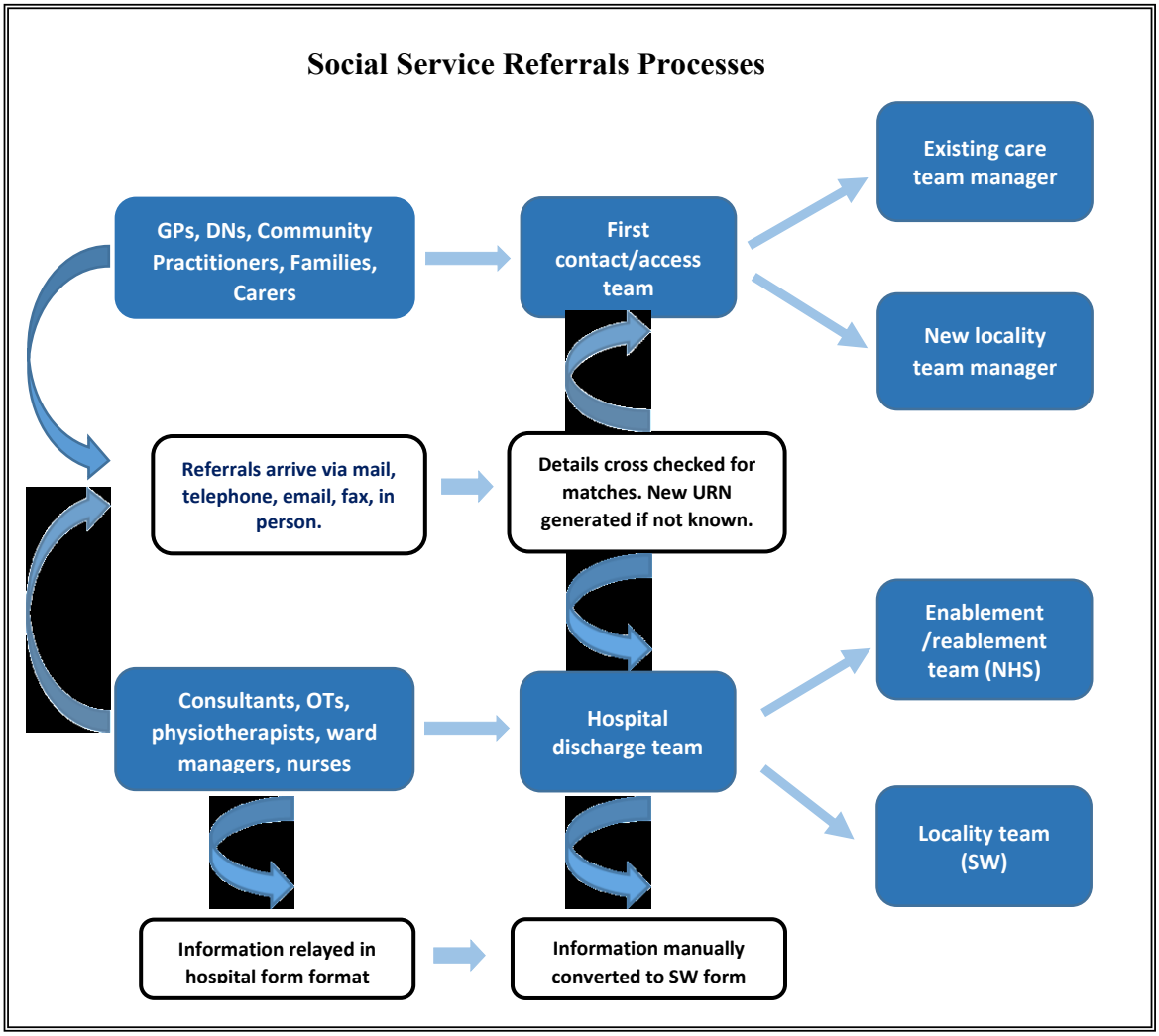


Figure 8. Social service referrals processes for community localities and hospital settings.

5.2.2. Data Collection in the Community

Whilst observing in the field, numerous referrals were witnessed arriving at social work departments; letters from GPs alongside hand written requests for services from individuals or their families/carers. Referrals were also relayed via telephone, fax and in

person. When observing referrals being received into community social work departments, there were many submissions where essential information was conspicuous by its absence, regardless of their origin or means of delivery. Many telephone calls resulted from social workers attempting to obtain these important details. For instance, common omissions included basic pieces of information such as permutations of client's full name or address, date of birth, doctor or practice name and address, or Community Health Index (CHI)[6]:

> *'Sometimes they're no very good, the referrals that come in. They're a bit scant with the information. I'll show you. This is one that's come from the hospital. This is an occupational therapy, a wee skinny em, folder. This is a fax that's come from [name of health board], like [name of hospital] and em, it's from an occupational therapist. Sometimes we struggle with the handwriting and everything.' (Interview, Site 2, P201, Administrator, Tuesday, 04/10/2016).*

Medical terminology and symbols were often used, confusing some administrators. However, those who were co-located with healthcare staff found support when these instances occurred:

> *'Social work aren't familiar with some medical terminology used on referral forms. [Name of social worker] explained that the symbol # can also mean a fracture.' (Fieldnote, Site 2, P203, Social Worker, Thursday, 06/10/2016).*

There were numerous explanations provided by social workers as to why information was lacking. For instance, if referrals were submitted by the general public, most did not what to provide therefore, would not always include a client's date of birth, GP or practice name in a letter. In the case of community district nurses, occupational therapists (OTs) or Physiotherapists, these referrals were generally communicated during community practice centre multidisciplinary team (MDT) meetings, via telephone, fax or word of mouth. During these occasions, necessary pieces of information such as a

[6] NHS patients are identified by a ten digit CHI (Community Health Index) number. The number normally comprises a person's date of birth (DDMMYY) followed by 4 digits; 2 randomly generated; the 3rd indicates male or female (odd for male, even for women) and one further check digit.

client's CHI number or date of birth were not always to hand. Administrators and social workers would subsequently telephone a wide range sources to obtain relevant information, and this observation was consistent within and across local authorities. Some staff complained bitterly that this practice took time away from what they viewed as other more important social work duties, whilst others were more accepting of the task as part of the territory of the role. Consequently, large offices often resembled a call-centre type atmosphere. Noise reducing walls were installed in most large office localities, which ameliorated sound levels. However, where these were absent, noise levels were high. Staff would become frustrated having to request callers to repeat statements. Other colleagues would be asked to talk quieter during such occasions, (sometimes abruptly), but then apologies would normally follow, impacting working relationships. Bourdieu referred to the concept as 'symbolic capital' in his theory of practice (234 p.171) to overcome work crises situations through symbolic gestures, rituals, or 'fair words' in order to regulate the routine of the ordinary, masquerading as a form of economic capital (234 p.178):

> *'On reflection I felt it must be difficult to concentrate in this environment. I thought about the reports social workers produce which required high concentration levels particularly with complex cases. Also, social workers spend an awful lot of time on the telephone and couple that with a busy office with no sound boards makes no wonder.' (Fieldnote, Site 3, P305, Social Worker, Wednesday, 23/08/2017).*

Once a social care team had been assigned to a new case in the community, the client record was electronically allocated to a team social worker or assessor depending on the complexity of the case. Social workers, (also known as care managers[7]) looked after more complex, on-going multi-agency cases, 24-hour provision or adult protection issues. Care assessors (also referred by some councils as support workers) tended to

[7] The difference in job titles evolved from social care going back to the 1970's. For example, during that time support workers in social care traditionally originated from either a nursing or social care background. Some were promoted, performing the same complex duties as a social worker but this title was reserved for those who had completed a 4 year social work degree course. Individuals carrying out social work whether were promoted through the council process (nursing or not) or through a social work degree did the same job and received equal salaries. However, unless an individual held this undergraduate qualification they could not be called a social worker. The title Care Manager was subsequently introduced. Some councils call all social workers Care Managers whilst others distinguish between a Social Worker and a Care Manager. (*Fieldnote, P102, Site 1 revisit, 02/10/2017*).

handle lower-level interventions or straightforward cases. Examples of these include one-off community alarm requests, key safe provision, domestic services or basic care packages. The following extract depicts how one care assessor described her role:

> *'I'm an assessor for social work services. So that entails me going out and assessing people in their own home; looking at their environment to see if there's any occupational health therapy or physiotherapy that's needed. To look at their ability skills to see if there's any social care that's needed, to look at social interaction to see if there's any support needed from day care, befrienders; financial assessments to see if their benefits are maximised. Em, look at carers support, carers assessments, carer support services em, of course if there's any pets in the house, are they being well cared for? Just what family members do, so it's the whole shebang really. It's not just what you're presented within a referral. You have to look at what's behind the referral and how things tick. And are they ticking ok?' (Interview, P203, Site 2, Social Worker, Thursday, 06/10/2016).*

During observation periods, administrators and social workers were asked to talk through what they did and why in relation to completing a variety of social work forms. These included documents that explained the necessary risk/priority factors to qualify for care alongside definitions of community care need. Local authorities developed their own versions of documents but each followed legislation and government guidelines set by the Public Bodies (Joint Working) (Scotland) Act 2014 to deliver health and social care services in Scotland [(15)].

Once a client met the set criteria, an appointment was made to carry out a full assessment of need in the client's own home or normal place of residence. A total of 16 social workers were accompanied, (a mixture of care assessors and care managers) over the duration of the research to find out how this information was collected. Each used their own practice style to gain the necessary information to determine whether a care package or other services were required. For example, some care managers took the assessment form with them on client visits and systematically went through each relevant part of the document. Assessment form size varied across districts ranging from 6, 20 and 40 pages in sites 1, 2 and 3 respectively. Others adapted the assessment form by copying and

pasting self-made prompts to serve as a reminder to ask applicable questions. One social worker created an A4 sheet of bullet points as a replacement for the assessment form which was enclosed in an opaque sheet protector. The sheet was discreet in appearance and because of the opacity of the protector, it was difficult for others to see its contents at first glance. During this particular care manager's assessment, she would, from time to time glance subtly at her make-shift document during conversation but continue to talk with the client in a manner that was relaxed and informal.

Afterwards, when querying her practice style, she explained she favoured a less formal approach to gathering information, adding that by the time a client is deemed in need of care they are already in a state of crisis with many uncertainties in their lives. The idea of a formal assessment can be overwhelming and frightening for most, especially for older people or those living with frailty. She therefore felt that talking with the client was the most helpful approach to build a relationship and also to get a better picture of the client's situation. This social worker was accompanied on numerous assessments where clients seemed oblivious to her actions making the assessment process seem sensitive and tactful in a reassuring way, ultimately minimising potential distress in my view:

> *'[Name of social worker] arranged to re-visit at a later date. [Name of client] was happy with that. I was so impressed with [name of social worker] ability to engage with [name of client] in what seemed a very genuine manner. She was very tactile, and held [name of client] hand making eye contact all the time – but not in a displeasing or awkward way for him. She got on her hunkers[8] so that she was looking up to him when she spoke. She remained like that throughout the conversation in what must have been an awkward position for her. Her proximity appeared comfortable for him and not invasive of his space.' (Fieldnote, Site 1, P102, Social Worker, Tuesday, 02 02 2016).*

Working outside the standardised protocol provided autonomy with what was perceived to work for the benefit of the client balanced against what was formally required by each

[8] The term 'hunkers' is Scottish colloquial language to describe someone squatted or crouched down low.

local authority. This type of parallel practice was noted by Grant and colleagues when observing GP practice receptionists and how they handled patient test results [268]. Receptionists performed contextual informal organisational routines to maximise patient safety versus the delivery of a test result. Additionally, Swinglehurst and Greenhalgh observed similar behaviour exhibited by administrators who summarised electronic patient records in GP practices. Summarisers off-set task quality on behalf of patients (unofficially) against GPs (officially), juggling their moral responsibility to patients and formal accountability to their employer (GP) [220]. In social work and other organisational contexts, the art of collecting information was more than just about obtaining the facts of a case.

As the study progressed, and following more observations and conversations with staff, (formally and casually) it became clear that the majority of social workers did not take an official assessment form with them on home visits, preferring instead to assess by talking with the client, listening and making short notes in a discreet manner. Client visits demonstrated how little information was collected in form format and that most was stored in the memory of the social worker or through very brief notes:

> *'I collect information through a story telling approach. When assessing a client one of the first things I ask is, "so, tell me, what do you do as soon as you get up in the morning?' (Fieldnote, Site 1, P105, Social Worker, Wednesday, 06/03/2016).*

One could argue there was a risk some information could be overlooked between the visit and recording the event back at the office. However, from what was witnessed when scrutinising staff uploading information to IT systems, there seemed an incredibly high level of accuracy and integrity in terms of what data was provided by clients and recall of this information by social workers. Equally, some information was gathered by other senses; rather than through verbal accounts. For example, social workers made mental notes of home conditions and potential hazards that may prevent a client to remain in their own home. Amenities such as appropriate heating, accessibility and adaptability were recalled back at the social work department although no questions were asked of the client at the time. For example, one assessor recorded a lack of hand rails and a raised platform in the shower room of one client which posed potential hazards, although

no mention of these had occurred during the visit. Cases were followed as they progressed, attesting to how data were recorded and how services were implemented. The following extract from field notes illustrates the progression of one client's pathway. The referral was made by the community mental health team who expressed concerns of social isolation for this 86-year-old widow following a diagnosis of dementia:

> *'During assessment [name of social worker] also mentioned she could arrange a welfare officer visit in order to carry out a full financial assessment to find out if [name of client] needed to contribute to her outings. The client and daughters agreed. [Name of social worker] then offered a fire safety check which could be arranged between the family and the local fire station to which they also agreed. [Name of social worker] noted the information gathered in her small notebook and took contact numbers for the daughters and son…. Day 4. I met [name of social worker] and she showed me the next stages of [name of client] case. The client was referred by the mental health team for additional support. [Name of social worker] showed me the client's report and care plan which were now complete and on the system. A financial assessment and fire check had been arranged. [Name of social worker] was able to confirm a placement at the local day centre for her client. She contacted the family who seemed delighted. [Name of client] day centre visits commence next week. The process from start to finish took just 10 days.' (Fieldnote, Site 3, P304, Social Worker,* Tuesday, 29/08/2017*).*

A wide range of practice styles and approaches were observed during home visits as one might expect, and methods seemed dependent on individual staff differences and how long a care manager or assessor had known the client and area. Some workers showed empathy whilst others were more pragmatic. Some used humour, colloquial or sometimes coarse language in context of the situation. Others applied a mixture of styles to suit client personalities. Each approach can be represented as a network in its own right from an ANT perspective which was then connected to other networks (clients and workers) offering numerous permutations of larger networks at force [(227)]. These networks also demonstrate the continuous movement of diverse actants and networks in

perfect translation in order to collect similar information. The following extract from field notes offers a sense of approach one care manager employed and who had come to know one married couple who she had served over months of visits:

> *'[Name of social worker] always responded with humour and you could tell [name of couple] enjoyed the banter. [Name of client] would often swear but it never seemed offensive. It was his way of communicating and it was always in good humour. [Name of social worker] never took offence, neither did I. Afterwards, [name of social worker] said that she wouldn't talk to all her clients the way she spoke to [name of couple]. I sensed she felt she had to justify her approach but to me it was appropriate and did not require any defence.' (Fieldnote, Site 1, P107, Social Worker, Wednesday 30/03/2016).*

When reflecting about similarities and differences in practice styles, there were no consistent patterns of behaviour across sites or within departments, certainly as far as gathering information was concerned. Consideration was given to age, length of service, seniority and other backgrounds such as marital status, home and family dynamics. It transpired social workers behaviours exhibited similarities and differences that did not appear to map on to attributes of age or experience. Thoughts were also afforded to different office spaces and how different locations, configurations and professional group dynamics may have influenced practice styles. Here, disparities were observed due to agile working arrangements, office space environments and other organisational and professional factors which impacted how social care data were evaluated. For example, a great deal of informal learning took place when staff were permitted to sit where they chose rather than adhere to local authority agile working policy. Additionally, health and social care staff who were co-located formed inter-professional relationships creating mutual understandings of different professional roles and were more cohesive during shared decision-making. However, departments that observed an agile working policy were in contrast to designated NHS funded work spaces for health colleagues who worked from the same office. Disparities such as these affected working relationships, impacting joint working ventures and are discussed in later chapters.

5.2.3. Data Collection in Acute and Community Hospital Settings

Procedures to refer a patient to social work from acute and community hospitals were embedded in practice and ward referrals were witnessed on numerous occasions. NHS hospitals held their own version of a referral form which was forwarded to social workers in the hospital discharge team. When received, social workers transferred information manually across to their own template and IT system. Referrals were delivered by various means, including via fax, internal mail, email, by hand or during MDT meetings (Figure 8).

When comparing social work and NHS referral forms, both served the same purpose but required different information making the entire process inconsistent and inefficient. Social work staff complained in that they were less informed than they could perhaps be. For example, the hospital referral form did not contain a section on CPR (Cardiopulmonary Resuscitation) status whereas social work did. Similarly, social work did not contain information on risks regarding IV (Intravenous) drug user/violence/aggression/pets whereas the hospital form did. Potentially important information to communicate. Social work stated gender as opposed to the hospital approach of male or female only, excluding contemporary understandings of gender. Likewise, the hospital version did not include information such as ethnicity or religion, whereas social work did. It was noted later that religion and ethnicity are recorded on patient ward files, however this information is not transferred to the hospital social work referral form.

The hospital referral contained a narrative space to comment on functional ability and mobility issues whereas social work portrayed a coded list of manual handling and mobility aids – similar information recorded but different terminology applied. Other disparities between the forms included discharge date versus **planned** discharge date which in reality related to two totally different constructs. These clauses were incorporated differently in respective paperwork hindering consistent transfer of information. In any case, hardly any were ever completed by either organisation during observation periods adding yet another layer of inconsistency in transferring or sharing of details:

> *'I asked [name of social worker] her views. She felt there was a definite difference in terms of what information was shared between professions. [Name of social worker] showed me a referral form sent by the ward and a referral form sent by the consultant to the psychiatrist [for the same patient]. So, one form was medic to medic, the other medic to social worker. They were worlds a part in terms of the amount of information provided. The referral from the ward was very brief with no background information. Whereas the referral from consultant to psychiatrist was comprehensive. [Name of social worker] used the words 'club' and 'it's not an equal partnership' to explain the differences.' (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).*

When being reflexive, three main thoughts emerged; priority, consistency and standardisation of data. On one hand, one could dispute the need for including certain information on respective forms particularly considering the urgency of a referral versus collating potentially superfluous information that could be obtained during a subsequent full assessment. On the other hand, fundamental elements such as gender and race were inconsistent, consequently clouding accurate transfer of core details. Therefore, forms could benefit from being fine-tuned in their mandate as well as being standardised in terminology of essential information. Additionally, a reduced directive may encourage fuller completion by referrers, expediting the transfer process.

Ordinarily, OTs, physiotherapists or nurses on wards would refer or be requested to refer a patient to social work. They would complete what information they had to hand on the pre-formatted referral form. More information was included if they knew the patient, than if the patient was unfamiliar to them. Ward staff seemed to view the delivery of the referral as the priority with completion of information a secondary thought and considered the latter as the role of the social worker. Some ward staff were not fully aware of correct procedures therefore completed what information they thought was required. These referrals were not fully completed in almost all circumstances. It was commonplace for the discharge team to receive a referral containing the name of the client and the ward number only. When asked why information was scant one nurse said:

> *'Oh, it's not a problem, social workers just phone up and ask if they need more.' (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).*

These actions, termed first-order problem solving were illustrated in Tucker and Edmonson's ethnography investigating exceptions or problems around healthcare management and organisational behaviour [(293)]. Nurses were found to implement a solution without addressing the circumstances that caused the problem in the first instance. Consequently, workaround problems became routine and seemed normalised. The application of second-order problem solving may have prevented ongoing issues. This is where the underlying cause of a problem is either fixed by individual effort or communicated to those in a position to remedy.

Subsequent observations indicated that nursing staff did not seem to know or appreciate the amount of time a social worker spent seeking information. This is particularly relevant considering the aim is to see a client within 24 hours of referral and meet a 72-hour deadline. A care package then has to be confirmed before becoming a delayed discharge statistic following a planned date of discharge (PDD). When exploring ward staff views, some maintained PDDs were arranged well in advance and although this was witnessed, there were many occasions where social workers had 72 hours (or less) to implement a package of care:

> *'It meant she had to return to the office afterwards and gather what information she could on the new patient. The next MDT meeting was not until Thursday, but [name of social worker] was on annual leave then. She said she would re-visit the ward later in the day to provide an update. This would have been avoidable if she had access to information.' (Fieldnote, Site 1, P109, Social Worker, Tuesday, 05/04/2016).*

Social workers would attempt to obtain vital information however, this was never straightforward resulting in delays in care planning. For example, during observations, social workers would telephone or visit a ward. The person answering the telephone or present at the ward station was invariably different to the person who made the initial referral, and perhaps did not know the person due to shift changes or annual leave. This person would spend additional time looking for someone who knew the client/patient.

Phone calls to wards also meant distracting clinical staff from tasks in hand adding to an already busy setting and probably time away from their patients. A disproportionate amount of time seemed to be spent gathering this necessary information which in isolation may not seem much of an issue, however on a daily basis, against considerable time pressures and increased work load was frustrating for social workers.

Some clinical staff maintained that social workers could obtain a lot of pertinent information by asking the client directly, and indeed this was witnessed on numerous occasions. However, as social workers pointed out, information often needed was already obtained by ward staff, therefore there was deep-seated reluctance to repeat questions to people who were unwell and in a vulnerable state. Additionally, and in contrast to healthcare staff, local authority employees operating from the hospital discharge team did not have access to electronic patient records in order to obtain information for themselves. They did however, have access to ward notes but these are typically disorganised, different professions filing information in different parts of the medical file meaning lengthy periods of time sifting through the notes to obtain relevant details.

Social work staff performed workarounds to help cope with poor workflow design or other organisational obstructions. For example, health colleagues working alongside the discharge team would assist by accessing electronic information on their behalf. Workarounds were synonymous with findings from Debono and colleagues in their scoping review of nurses' workaround behaviours in acute settings [294]. They reported workarounds which were enacted individually and collectively. Some were viewed in positive terms as temporary fixes; necessary to deliver care and in the best interest of the client. Others expressed concerns over an unnecessary use of organisational resources and an increased risk to patient outcomes. The following extract illustrates how the client became displaced by becoming abstract in the form of information stored on an IT system then through various translations re-assembled in different places and different times:

> *'And people are **really** good and will give you the information (emphasis in the original). But if they're not around, then you just base your decision on the information that you've got to hand, which is not great, you know, when*

> *you think, you're expected to do an assessment* ***really, really, really*** *quickly (emphasis in the original). And there's a whole chunk of information quite often that's held on someone, that you don't have access to.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

Whilst observing, there were occasions where ward staff would chase a referral to find out what stage it was in the system only to hear that it had not been received by social work. There were no formal procedures in place to check delivery or status at the time of observing. Moving from the receipt of a referral, gathering as much available client information as possible, the Hospital Discharge team then conducted what is called an 'assess to discharge' *(Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016)* rather than a full adult assessment. The initiative behind this process aimed to expedite patient pathways with a view to discharge in a timely manner followed by a full assessment when settled back into their own environment:

> *'So, what we've just recently moved towards, particularly in the acute setting, is doing a hospital discharge assessment. Which is really about focusing on what it is that brought the person into hospital, what it is that they think they're gonna need, or the MDT feel they're gonna need to discharge them. So, it's a more immediate need as opposed to a long term.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

There are two streams to this process. There is a health team and a social work team both operating from within the hospital discharge team. Teams decide together through screening to determine which pathway is most appropriate, either through rehabilitation or enablement via the hospital team or community care through the social work team. Exceptions to these procedures would occur if 24-hour care was required in which case a full adult assessment would be conducted. In any event, information was recorded on both the hospital and social work IT systems in isolation. People discharged into the community had their physical file delivered to the locality team as there was no electronic means to do this.

When interviewing and observing members of the hospital discharge team, many expressed concerns over what they termed 'revolving door' incidents *(Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016)*. This is where clients are discharged under social work care and who are provided services under a locality team, but are waiting to be assigned to a specific care manager. This means clients in this situation are not being monitored or supported and end up becoming a 'failed discharge' as described in the following extract:

> *'So, they've not been allocated, and in the meantime, they come back into hospital which means they won't get allocated, but then they get another service, go back out, they're still waiting to be allocated. Potentially, they could have 3 or 4 admissions and 4 or 5 duty calls and be responded to in the community through a duty system, but never actually be allocated to a worker.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

There was a profound recognition of unallocated clients being discharged into the community and new processes have been trialled to help cope with the burden. However, one hospital reported at least 150 unallocated clients at any one time making the task of identifying these people difficult particularly under present budget constraints. Efforts continue to enable a more proactive rather than reactive discharge system, but as one manager commented:

> *'Re-designing a system is one thing, re-designing a system while making big cuts in it; that's an interesting experience.' (Interview, Site 1, P103, Social Services Manager, Monday 08/02/2016).*

Currently, hospital discharge teams flag people who they think need urgent allocation and this has resulted in approximately 95% of identified clients being assigned a worker on discharge much to staff relief. Future analyses may be able to illustrate whether this strategy has resulted in fewer failed discharges.

5.2.4. Data Collection Out of Hours Services

Out of Hours (OOH) services are manned by duty operators, normally in isolation. OOH staff do not have the usual 'real-time' colleague interaction or support, meaning immediate access or offers of professional help or other information are limited. Staff in one particular council voiced difficulties in obtaining information during a crisis situation due to restricted access of client information. Information was normally garnered from individuals at the scene and duty members had no way to corroborate the accuracy or integrity of information provided. Information gathering was consequently lacking and inconsistent in this context.

This became clear when attending a workshop for OOH staff, designed to refresh awareness of Adult Support and Protection principles, policy and practice. The group discussed different scenarios where procedures aimed to guide practitioners could sometimes cloud what intervention to carry out. A common sense, in-context approach was their best guide to action in most cases, which in such a sensitive and litigious field left many feeling unsupported. When referring to grey areas such as risk of harm versus lifestyle choice, one member said:

> *"I can arrive at a crisis scene, have little or no background information, I then have to rely on what information I can get hold of at the scene and more often than not, I'm never quite sure what to do in cases like these" (Fieldnote, Site 1, P102, Social Worker, Wednesday, 24/04/2016).*

Workshop members made reference to applying knowledge gained from previous experiences and training, besides information learned from co-workers or collaborators; internalised sequences of multiple thought processes. For example, during the workshop the convenor presented three different crisis scenarios and asked each group to describe what actions they would take to bring about the best client outcome. From the three groups formed during the workshop, each offered different actions and explanations to bring about a resolution, using the above sources of information rather than draw from formal local authority procedures. All groups achieved the same end i.e. the best client outcome. This example also illustrates the different range of actant and network activity that can influence other networks to bring about the same outcome.

These types of scenarios and behaviours were synonymous with those described in a prominent paper by Gabbay and Le May published for the British Medical Journal (BMJ) [295]. The authors explored the use of formal guidelines and context-specific, ad hoc ways practitioners performed during situations on the ground. They applied the term 'mindlines', to routine day-to-day practices which collectively relied upon internalised tacit knowledge built on initial training and experience, alongside formal and informal interactions with trusted colleagues [295 p.3]. The article suggested these social processes offer a buffer against rigid 'cookbook' adherence to codified knowledge (guidelines), giving emphasis to the power of local context [295 p.4].

During this workshop, another member mentioned information that was difficult to obtain. But in this instance, it was not just about access to information. Rather that information was not communicated through disconnected systems and this was a consistent finding across sites. Social workers were at risk of attending crisis situations without correct information particularly guardianship or power of attorney details:

> '*Capacity information is normally stated in a client's care plan if they are already known to social services. However, OOHs are not permitted access to that information. [Name of social worker] and convenor of workshop mentioned that even if a client was deemed incapable, it will not always be recorded on social work files. She explained that a client could hold capacity during the care planning process, but then develop incapacity months or even years later. And because medics [GP, Psychiatrist, Consultant] are the only professionals allowed to determine capacity, this information would be recorded on GP and other medical records. She emphasised that updated information does not always filter through to social work.' (Fieldnote, Site 1, P102, Social Worker, Wednesday, 24/02/2016).*

It transpired that OOH staff did not have access to medical records (in parallel with day staff) which again meant lengthy telephone calls trying to find out basic information. From 15 OOH social workers in attendance at the workshop, all expressed concerns over a lack of access to information which was primarily due to two local authorities who shared OOH services but whose client information systems were not linked. The

remaining local authority operated a stand-alone OOH service incorporating one IT system meaning information accessible to day workers, including client case notes were also available to OOH teams. Information could therefore be quickly and accurately acquired allowing decision-making that facilitated appropriate care intervention during a crisis situation.

5.2.5. Ongoing Data Collection

Keeping records current was a continuous struggle for most social work administrators where departments were reliant on a variety of sources to keep data-bases up to date. Key information was often delayed or not forwarded at all at the time of observation. One of the most important considerations was the death of a client. It was common for departments to receive this type of information weeks later, often communicated by grieving relatives after receiving an invoice or other social service correspondence. One local authority resorted to sifting through the obituaries section of local newspapers in an attempt to keep up to date. I have applied bold print to the participant in this extract to differentiate from the researcher's words:

> ***'P201. We've to read the local paper to find out about the deaths or if one of the workers tell us somebody's died, we have to go in and record them deceased, close their services, let relevant workers know, let finance team know.***
> *R. Is there no formal procedure for someone to inform of a death?*
> ***P201. That is the formal procedure.***
> *R. What, you have to go through the newspapers?*
> ***P201. Yes.' I mean I had one last week, had been dead a few weeks and the relative had phoned finance, because they wanted their invoices stopped and the package stopped. But they never passed that information on to us. And then I got a cheeky email from somebody in finance saying this person's dead, please mark as deceased. But nobody told us. So I had to kinda go in retrospectively and mark this person deceased.*** *(Interview, Site 2, P201, Administrator, Tuesday, 04/10/2016).*

This rather arbitrary system seems inappropriate and in contrast to a systematic process of gathering information consistent with current societal expectations.

5.3. Client Data Coding

5.3.1. Initial Coding

The completion of a client assessment in the department office took a more systematic approach than the less formal affair in a client's own home. There were numerous forms and procedures that a social worker had to navigate to commence, continue, change or stop a service. Initial client consent, assessment or SDS (Self Directed Support), care plan, outcomes plan, funding agreement, service request, care allocation, case review, and recommendation for care home/nursing home are but just a few examples. The nature and diversity of procedures were daunting even for the most experienced social worker. As one long-serving and knowledgeable assessor put it:

> *'Well, you've seen what the forms are like; nightmare. Absolute nightmare [laughs].' (Interview, Site 2, P203, Social Worker, Thursday, 06/10/2016).*

Social workers began documenting an assessment by uploading the client consent form to respective IT systems and where hard copy files were held, a paper version was also maintained. Client data were also uploaded where coding took a variety of forms; either through drop-down menu options meaning data were back system coded or in free text form meaning it was largely un-coded. Most of the information witnessed being uploaded incorporated these techniques.

When recording an assessment, client details were retrieved from the IT system and an assessment form was opened using their unique reference number (URN). Core details such as name, URN and date of birth were automatically incorporated into the assessment. Fields were displayed where other pertinent details were input. For instance, a client's personal profile; details of their circumstances (type of accommodation, managing at home, social and financial particulars) were uploaded and this was accomplished by using a combination of drop-down menu options and text form for all councils. Options for eligibility/risk factors were signposted and selected through a drop-down menu of high, medium or low risk and these were back system coded as were most of the core questions. More nuanced information was documented in text form which provided the context to a client's situation.

Each IT system had capacity to store all documents. Every interaction social work undertook with a client (or on behalf of a client) was recorded on the electronic data base in respective social work offices. This included correspondence and case notes (also known by one council as profile notes) detailing client visits, changes in care packages or personal circumstances. The level of detail recorded would depend upon each situation. For example, a client visit would be recorded as a case note by a social worker, incorporating date/time, occasion, who was in attendance, contextual information and outcome. If a letter was received, this would be held on the physical file and a short case note applied to the electronic account to reflect this. Similarly, if a telephone call was made or received, this would be noted on the system as a brief case note. These would be updated by a variety of staff such as care/service managers, OTs and social work administrators depending on the task.

One local authority operated a totally paper-free system, whilst the other two held hard-copy duplicate files for every client. Thus, councils operating in electronic form only who received letters would scan and upload hard-copy documents to client case notes. Staff working at the remaining two councils operating a dual system were required to reproduce everything input to their IT system in order for documents to be stored in a hard-copy format.

Some members of staff were more meticulous in their recording than others. It became apparent that when social workers inherited cases, some detailed information on case notes were lacking. This came to light when an existing client had been referred to social work by carers who expressed concerns over potential financial abuse by a family member. The carer noted previous visits by social work staff however, no details of these events could be retrieved from the client's case notes. It transpired, recording patterns were heavily dependent upon individual practice and team leader management style.

5.3.2. Continuation Coding

Each new or subsequent event involving a client meant updating the client file electronically and in hard copy where duplicate files were held. Several social workers felt some information which required uploading to their system (which the system would sometimes code in the background) was incidental and unimportant, for example ethnicity, religion and nationality. It was interesting to note that when viewing these

criteria from the client management system, options for nationality included: 'White Irish, White other, White other British, White Scottish, but there was no sign of English or Welsh preferences or any differentiation between Northern and Southern Ireland possibilities, belying a sense of rationale.' (*Interview, Site 2, P201, Administrator, Monday, 04/10/2016*).

> *'I was engaged in a conversation with some experienced social workers who had worked for the council for a number of years. I asked for their views of information gathered on forms and what they thought was useful to collect and why, and also if there was information collected that was unhelpful and why. Straight away, I received heated replies saying that they felt asking someone's religion or ethnicity was irrelevant. It was very interesting listening to their explanations. I was inundated with opinions such as 'we're employed to provide a service, not pry into someone's ethnicity or religion' 'we don't need to know that'. They felt that these issues do not and should not have anything to do with the quality of care a person receives.' (Fieldnote, Site 1, P105, Social Worker, Wednesday, 16/03/2016).*

Initial and ongoing coding was performed through allocating drop-down menu options to a wide range of mandatory local authority forms. Free text notes were uploaded to provide the context behind each client situation. The volume and type of information collected very much depended on individual practice style and experience of each social worker as well as team leader management style. Not all records were maintained accurately highlighting the difference between formal procedures and reality of practice on the ground.

5.4. Summary

Day-to-day information collection processes have been the main focus of this chapter encapsulating entire process relating to a social work referral, assessment, and care provision for older people in three local authorities in Scotland. The three field sites under study revealed a broad but common framework of legislated actions which authorised staff to gather information, although local variations were noted across regions. Whilst keeping identities of participants and locations concealed to protect

anonymity, a step-by-step account has been presented to illustrate how data originated. Different origins and channels to which referrals travelled in order to request, change or stop care services were also highlighted. Variance in staff practice styles, language and terminology between and across agencies illustrated the complex and real world of health and social care organisations. Gathering information is not a one size fits all scenario but rather a fluid mix of innumerable contextual permutations. Workarounds were key to meet poor workflow design, inconsistencies with information quality and a dearth of access to information, forcing the necessity to operate outside standardised protocols on many occasions. From this broad base of data gathering, key factors emerged which impacted the social care assessment process and management of information. The next chapter examines these aspects in more detail to bring a deeper understanding of the challenges and opportunities experienced by the wide range of staff engaged in health and social care service provision.

6. CHAPTER 6. KEY FACTORS FROM THEME 1 – DATA COLLECTION AND MANAGEMENT BY SOCIAL CARE STAFF

6.1. Introduction

An initial referral to social work, the provision of social care services and ongoing monitoring, are established through a wide-ranging set of procedures facilitated by recording client information. The previous chapter reported a general picture of tasks performed by social work departments in order to meet government legislative care. The examination and resulting overview of findings highlighted some successful but also challenging insights. Key factors emerged which influenced the operation and flow of information often expediting, but sometimes hindering client care pathways. This chapter now examines these elements in further detail to portray the views and experiences of social care staff at executive, service management, analytical and front-line levels of operation. The following section reports a core aspect of client information processing, 'information sharing'; a fundamental activity in the assessment, planning, provision and review of social care services. The chapter then describes other key features that shaped data processes; access to information, duplication, data discrepancies, communication, expectations and decision making.

6.2. Information Sharing

There were many examples to suggest information sharing processes worked well particularly between social work departments and organisations such as ISD (the analytical arm of NHS), the Scottish Government and health and social care partnerships. MDT meetings on hospital wards and in community health centres were other positive examples of increased sharing. Additionally, significant investment had been injected to enable links to health and social care systems as one local authority highlighted (although the systems were not yet in operation):

> *'We've invested £150,000 in the interface between [name of local authority IT system] and [name of healthcare IT system] ……which hopefully will allow better data sharing.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

Improved information governance at national level made it possible to develop data sharing protocols to facilitate better co-operation and sharing of information at regional and local levels. However, that is not to say this was straightforward in reality. As with any new venture, it has to be remembered that change takes time to become embedded in practice as noted by Holt and colleagues [296]:

> *'I think, this is something that's improving all the time actually, I think initially it's because the partnerships were entirely new entities and everything was em, you know, a metaphor used was a washing machine; see what comes out. Everything was churning around, things seemed to be quite randomly coming up as and when. Not so much fire-fighting, there was just a lot of things that were quite unexpected coming upon the partnerships. And now things have started settling down a little bit. It's, there's a lot more around looking at the bigger picture, seeing projects going forward and em, maybe allowing to move around the areas of data development and looking at how the data can be better used as opposed to using it how it's always been used to just inform slightly different aspects of the service. Em, so that was maybe one of the major issues. It was kind of, I mean I don't want to say, well, I'm going to say it now, a lack of direction. But you know, it sometimes felt like it was eh, it was week to week, month to month as opposed to having a goal at the end of it. But I think now that it's been over a year the partnerships have been an actual entity as opposed to something happening in the future that it's starting to settle down a little bit. (Interview, Site 3, P303, Data Manager, Friday, 11/08/2017).*

There remained some instances where health and social care staff were more reluctant to share information despite data sharing protocols being in place. References were made to analysts who were external or alien to the locality or data origins, who may not have an understanding of data sets in context of regional or local differences. Results from such analysts were felt likely to add a different spin (normally negative) than from those analysts operating from within the locality of provenance who held a deeper understanding of those data:

> *'I can tell you that em, as much as we're health **and** social care, health can still be quite protective about their data, and who looks at it even when they shouldn't be (emphasis in the original).' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

There were other reasons for this aversion even though there was an overall willingness between the two organisations to co-operate. In the following extract, this data manager believed it was often fear of repercussions:

> *'In some senses because, em, because, you know, they understand, if somebody loses the data, then if you're from health to health perspective you get dealt with through the health process. If they transferred it from health to local authority, and I did something with that data, does that come back to health to beat them up? Or is that because I've done it. So, is there's a bit about, well if we let go and they use it differently, does that then mean that we're gonna get into trouble?' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).*

Some comments supported the opinion that health organisations were precious of their data when considering sharing information with social work. However, the following extract from a social work manager confirms that the perceived attitude of NHS was not a one-sided affair as similar beliefs resonated with local authorities also:

> *'You know, this is our data, and you're not going to tell us how we manage our data... [Social care perception of NHS staff who then went on to say]: I did it. I can, I can tell you that I did it too alright, so I'm not saying this from a point of view of being critical of others.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

Over the course of observations and interviews, it became apparent strong leadership, relationship building over time, co-location of staff and multidisciplinary team meetings helped to improve the sharing of information. Sharing information brought many mutual benefits to health and social care staff resulting in client care that was carefully co-

ordinated by a range of multidisciplinary teams. Technical enhancements and data sharing protocols aided these processes. There was however, some reluctance from specific quarters to share information, typically from an analytical perspective that risked the process of sharing to further evolve.

6.3. Access to Information

Access to information took many forms. For example, social work staff operating at the front line required access to local authority client management systems in situ as well as in remote locations or during OOH services in order to view or record information. Front line staff also required access to information from medical records or other third sector agency knowledge sources, whether from acute or community settings. Access to information was also required by managers and analysts so that service activity could be monitored and statutory reporting could be achieved. These dynamics are described as in the following sections which then lead to other key issues impacting data collection and management processes.

All participants mentioned access to client information. Some were complimentary where co-operation between departments and health and social care partnerships realised positive benefits to services, their users and managers. Others seemed to have more difficulty as highlighted below. Access to information could be view through two key groups. First, those workers at the front line of operations in local community services or acute settings. Second, from an analytical viewpoint through strategists, managers and analysts. Findings are reported in that order below.

6.3.1. Front Line Service Level

6.3.1.1. *Community Access*

There were numerous examples showing how access to information had advanced over recent times in response to health and social care integration strategies, although significant obstacles remained. Access to data was viewed as crucial from mobile, remote, local and head office perspectives. For instance, operating from mobile or isolated rural areas often meant returning to the office to obtain or upload information to IT systems. This routine practice was not always convenient or expedient. Community

health staff also commented on similar difficulties therefore it seemed social care did not have a monopoly over restricted access:

> *'We talked about sharing information and the district nurses expressed their frustration at not being able to access GP records when out in the community. If they needed information, they had to return to the practice. I remember thinking, so it is not just social work who had difficulty. (Fieldnote, Site 2, P206, Social Worker, Tuesday, 18/04/2017).*

One council had subsequently supplied its workers with laptops and mobile telephones in order to access its networks from a distance. Of the two remaining local authorities, one provided mobile telephones to its front-line staff and planned to follow suit with laptop provision, whilst the remaining authority were in the process of providing mobile telephones only:

> *'Yeah, so just now we can remotely access [name of local authority IT system) from anywhere in Britain in seconds. If I take my laptop at work for example, which I dock and it speaks to the system and I can see [name of local authority IT system]. So, when I go home, I can open it up and I can still see it, live.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

However, even here problems occurred around network coverage and patchy provision of equipment. For example, some locations did not have sufficient signal strength to communicate and where they did, connection was often slow even in some urban areas. Rural areas were worst hit. The following is a typical example of how staff expressed dissatisfaction in one particular local authority department:

> *'[Name of social worker] mentioned how she was frustrated by council statements that they could access emails via work mobile phones. She showed me her antiquated ZTE [model of phone] which did not have the capability to access emails. She was annoyed that care workers had been provided with smartphones and although she appreciated they needed to*

have communications and to be contactable, they did not require access to emails. She repeatedly requested a new phone but had been refused to date. Equally, [name of locality head office] boast workers as having the ability to access their IT system remotely. This however, involved the use of laptops provided by the local authority. Currently, [name of locality social work office] has just one laptop for the entire department therefore, there was much frustration when trying to book the equipment.' (Fieldnote, Site 3, P308, Social Worker, Tuesday, 26/09/2017).

Similarly, when operating from locality or head office bases, social workers obtained access to information by spending what appeared to be a disproportionate amount of time on the telephone and this was due mainly to limited or no access to other systems alongside inadequately completed referral forms:

'Whilst reflecting, I felt social workers spent an inordinate amount of time on the telephone. In fact, whilst thinking this I looked around the very large office of over 50 workers and lo and behold, the vast majority of care managers were on the telephone.' (Fieldnote, Site 1, P105, Social Worker, Monday, 14/03/2016).

Almost all staff accepted telephone call tasks as part of the territory of the job, adding that they felt telephone calls maintained a personal touch which they preferred in certain circumstances. Most felt relationship building was enabled and nurtured through this process, particularly when talking to clients or when communicating with other agencies. Telephone tasks became a source of frustration at other times as information which they felt should have been to hand was not, meaning often lengthy conversations attempting to acquire.

Access to information was also influenced by security settings incorporated into respective IT systems to facilitate different levels of access. So, for instance, a care manager would have access to every feature of client information belonging to his/her register. However, other people requiring access, for example, co-workers, community alarm staff, meals on wheels or other council employees had restricted access only.

Sensitive information such as assessment details, funding agreements or adult protection issues were not visible to personnel with limited access.

Restricted access to service user information through IT security levels was necessary to protect client confidentiality and to ensure information was accessible to staff on a need-to-know basis. However, these security settings became problematic for some duty workers or OOH teams as previously mentioned. One local authority enabled access to duty personnel ameliorating this disconnect. Even with this much needed provision, some local arrangements meant staff could not access certain elements. For instance, the locality office in question employed just one administrator who worked part-time. The department did not employ a duty roster meaning that random social work staff manned telephone calls during clerical absence. The electronic administrative calendar was accessible to clerical staff and duty workers only, which resulted in breakdowns in operation when attempting to co-ordinate appointments as demonstrated below:

> *'[Name of social worker] needed to confirm an urgent multidisciplinary appointment for a co-worker between social work, a client, mental health team and housing. The admin worker was out of the office for the day therefore [name of social worker] could not access the electronic calendar to inform involved parties. I watched as she spent 2 hours dealing with a 4-way conversation in an attempt to resolve the situation. [Name of social worker] felt this situation was unnecessary as a duty worker would have meant that this situation would never occur. (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).*

As fieldwork proceeded it transpired that some staff did not use the electronic diary anyway. There were no formal measures in place to gauge how accurate or comprehensively it was maintained or even if staff used this tool since the process was not monitored in this locality. These points draw attention to the need to access information in situ and remotely. Both were dependent on connection to IT systems where management reports of facilitated access were in contrast to actual work practices in the field. These weaknesses highlight the gap between formal processes and the reality of functionality on the ground.

6.3.1.2. *Acute and Community Hospital Setting Access*

From an acute or community hospital perspective, access to information had also moved forward with managers highlighting that social workers benefited from access to the hospital discharge system as illustrated below:

> *'We have staff who are directly linked into that system. We have staff who will record on it, who will update directly into the system, who will pull information from that system on a daily basis to look at where the delays to report back into that so we've actually got quite a high level of access to a limited number of people.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

In practice, access to the hospital electronic discharge system was indeed enabled to key staff members but this translated to one social work manager to cover one large hospital with over 800 beds. Additionally, this was the only electronic health system (of which there were many) accessible to social work staff. Staff worked around these limitations whilst acknowledging inadequacies:

> *'And people are **really** good and will give you the information (emphasis in the original). But if they're not around, then you just base your decision on the information that you've got to hand, which is not great, you know, when you think, you're expected to do an assessment **really, really, really** quickly (emphasis in the original). And there's a whole chunk of information quite often that's held on someone, that you don't have access to.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

Access to other hospital systems was not permitted to social work staff which hampered the smooth running and efficient co-ordination of patient pathways. For example, as noted beforehand, social workers did not have access to electronic patient records, in contrast to health colleagues working within the same hospital discharge team. Social work staff required access to information held on these electronic records on a daily basis and when in need NHS co-workers (administrators and health employed discharge team members) would assist. However, this proved an inefficient use of both

professionals' time. Additionally, social workers would engage with key hospital staff (consultants, ward managers, nurses, OTs, physiotherapists) to obtain client information. This was more-often-than-not performed via telephone or face to face communication rather than by electronic access. Again, one of the hospital team managers made the following comment regarding health staff access to electronic information which also seemed less than satisfactory:

> *'My clerical staff do [have access], 'cause they're employed by Health [NHS]. But they can't get access to [name of health IT system], so they need to go to, [pause] well, they've got bits of it. They go to [name of healthcare manager] clerical to get access through their system which is just a bit farcical. (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

It seems access to information was not only limited to social care staff. Overhearing a conversation between two health professionals at a community hospital MDT meeting illustrated the difficulties they faced when accessing information. Each adapted their practice to compensate for the shortcoming which helped to reduce the risk of harm and inefficiencies:

> *'I noticed each profession made their own notes – the pharmacy technician, consultant, nursing and support staff. I wondered what happened to this information afterwards and I was able to ask 2 x support workers. They said they kept their own notes on each patient and shredded them after discharge. One of the workers was part of the OT team whilst the other was part of the physiotherapy team. They felt it necessary to keep notes as one could not access the other's information on the practice electronic system. In fact, they emphasised that had it not been for their close working relationship developed over years, they would find it difficult to obtain, maintain or co-ordinate patient information and pathways.' (Fieldnote, Site 3, P307, Social Worker, Wednesday, 30/08/2017).*

Access to information meant relying on good working relationships and silos of informal data routinely collected to ensure co-ordinated client care pathways at this micro-level of operations. Data accrued were then destroyed at will. And although this practice worked well on the ground, the serious question of how this type of information was stored to meet data protection safeguards is of concern.

6.3.2. Analytical Level

There were many instances where access to information had greatly improved over the course of the research. There were several reports of strong and successful collaborations. Interestingly, access to specific forms of data were much improved due to the secondment of personnel from ISD to assist local authorities. Data sharing protocols implemented between ISD (the analytical arm of NHS), the Scottish Government and health and social care partnerships helped pave the way. For instance, local authorities were now in receipt of retrospective aggregated health data, which they could not access previously. Data were linked by ISD through CHI and URN's which offered the potential to better explore service use and planning with the capability of drilling down to post code level. Access progressed rapidly over the course of the project. For example, at the beginning of the research and during some of the first interviews, numerous narratives were offered to describe how difficult it was to establish what data were available, where to find these data and who to contact in order to request these data sets:

> *'Well, often it's like, you don't know who to go to so then you have to ask around, which is the right person so all that takes time. And then you might find out who it is, and then you find out that they can't actually get what you want. So, it's just really difficult.' (Interview, Site 1, P104, Data Manager, Monday, 29/02/2016).*

When grappling with procedures in order to obtain data, it seemed some were discouraged by the numerous and lengthy processes involved:

> *'You know, sometimes you just see it as hurdles and it's like oh, another hurdle to go over, and another hurdle to go over, and you just sit and think….*

But the bit that concerns you is the fact that the public think that we do this very easily with no hurdles what so ever.' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).

Others seemed bewildered over the number of documents that had to be signed to permit access to a single data set which was perceived as an ever-continuing saga:

'But there isn't just one document, there's ***soooooo*** *many documents (emphasis in the original). And then you think, oh well, that's us, we've signed all the documents, we must be really ok, we can get stuff signed off. And then they bring another document out. And it is just so frustrating, [Laughs in exasperation].' (Interview, Site 1, P104, Data Manager, Monday, 29/02/2016).*

One local authority council had little trouble obtaining data since relationships with government staff and ISD colleagues had been developed over the years through previous collaborative projects. This council was especially well developed in terms of data access, sharing and analysis. There were however, concerns over a lack of access to GP data:

'What we can't see is, we can't see what the GPs seeing and that's a major flaw. And my view on that is, if we could see what the GPs seeing, we would change a lot of our services tomorrow. 'Cause they see what's coming and we don't see it till it's an unplanned admission.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).

Other data managers reported encouraging progress regarding access to data and were hopeful of the benefits this would bring:

'We're getting there gradually. We've just recently had the CHI number from ISD, and we've put it on our system, so the future will be data linking but we're not quite there yet.' (Interview, Site 1, P104, Data Manager, Monday, 29/02/2016).

In terms of future development, some strategists were optimistic about continued access and collaboration with other agencies, particularly third sector and community health data set analyses. The following response demonstrates what potential such analyses offered to make health and social care more holistic and efficient:

> *'Because you can see the whole picture of someone's, the whole care pathway and not just for an individual. You can look at, for specific cohorts, and people and see where there might be differences in you know, inequity in their care em, compared to other similar cohorts, whether within the partnership or compared to elsewhere. And eh, it's just unfortunate at the moment that we don't have all that data, you know the community health data. That would be a very useful thing to have when you're looking at patient pathways. How much district nurse time they have, how much physio time….. (Interview, Site 3, P303, Data Manager, Friday, 11/08/2017).*

Access to information progressed speedily from an analytic perspective. Up until this time, local authorities lacked formal knowledge of the process involved to gain access to information and subsequently faced many obstacles. Through the development of data sharing protocols and collaborative projects with NHS, government agencies and partnerships, local authority managers and analysts were now in possession of linked health and social care information. These data offered great potential to inform service use and client care pathways, although there is still much to do to complete the data cycle with access to GP, AHP and third sector data sources.

6.4. Duplication

Many references were made to duplication where the same information was collected more than once from the same person or agency or collected from more than one source. For example, due to restrictions with access to and sharing of some information, staff in hospital discharge teams needed to ask patients questions they knew had already been asked by other clinical staff. Social workers felt uncomfortable having to repeat requests for information but did so reluctantly to accelerate information gathering, ultimately progressing patient care pathways. This replication also occurred in community settings where health and social care staff would gather identical information and upload to

different IT systems. This process was viewed as a necessary evil to ensure important information was captured in isolated systems:

> *'So, it will have all the same data in terms of identifiers, name, address, date of birth, etcetera, etcetera. It will have the same, or almost the same recording in terms of what happened in the issue. And the reason why you've got to double record is to pool the data for both systems, you've got to be able to have that information there.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

Duplication also occurred during the completion of the numerous forms within community care social work departments:

> *'Another observation in relation to data gathering is duplicated work. Many of the forms that [name of social worker] completes when she returns to the office involves a lot of duplicated information from one form to another. [Name of social worker] sees this as an inconvenience and a waste of precious time. She and many other care managers developed their own method of copying and pasting text from one form to another which limits time wastage.' (Fieldnote, Site 1, P102, Social Worker, Monday, 15/02/2016).*

One local authority developed what was termed a 'peek and grab' function which copied and pasted information from one form to another to prevent workers having to re-draft the same information. This feature worked well in practice for the particular local authority:

> *'It can effectively pull through what was done the last time and then you can add on to it, you can delete it. So, what it's basically, it's trying to save the time of re-typing it all the time. You can just keep pulling through what was done the last time and add on to it.' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).*

Two of the three local authorities held hard copy files meaning a profusion of duplicated information. Some care managers became defiant and refused to complete file work until she had attended to what she considered more important social work. Others were compliant and diligently maintained their physical files:

> *'I asked if I could see a file from the beginning of assessment through to allocation of a care package. I was shown one of her hard-copy files from her cabinet and the first thing that struck me was the amount of information held in the file. Assessment forms, consent forms [she obtains written consent each time she visits a client], case notes, care package details. In fact, everything recorded electronically, was included in her hard-copy file. So, duplication is common. I can understand why [name of social worker] did not complete her files. (Fieldnote, Site 1, P105, Social Worker, Wednesday, 16/03/2016).*

Service managers recognised the burden duplication created, not least in terms of use of time and resources and to the bewilderment of clients:

> *'The common problem just now is that we all do the same assessments on different people. You'll get 4 health assessments and 3 social care assessments and in actual fact, half that assessment's the same thing every time. We're asking you, oh 'who's your next of kin?' 'How many times do I need to tell you this' [laughs]. 'They've just asked that half an hour ago.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

One council was currently reviewing forms to produce more cohesive practices:

> *'I hope it gets easier, I hope there's one form for whatever it is and not 10 different forms for the same thing, which is the case now.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

One local authority operated a paperless system and did not seem to experience the same level of encumbrance:

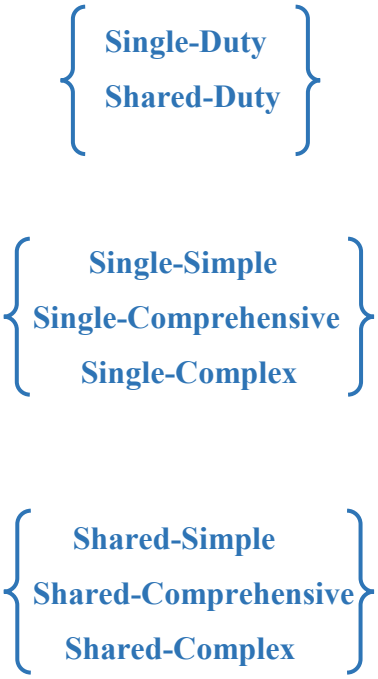
> *'I arrived at [name of locality social work department] to continue my shadowing with [name of social worker]. I asked if she found a lot of duplication. She mentioned that because they operate a paperless system, duplication was much reduced although specific events such as Adult Protection issues still involved considerable duplication. Some staff copy and paste repetitions, but [name of social worker] prefers to type as she goes.' (Fieldnote, Site 3, P305, Social Worker, Thursday, 24/08/2017).*

Duplication was viewed necessary under present health and social care configurations so that captured information was recorded on the numerous isolated systems. Local authorities introduced technical tools to reduce the burden when uploading data to client management systems or staff formed their own workarounds to minimise the obligation. One local authority was creative in using funds to operate a paperless client management system which worked extremely well in practice, ultimately reducing the burden of duplication.

6.5. Data Discrepancies

6.5.1. Knowledge and Understanding

When completing client reports, there were instances where social workers did not fully understand some questions on local authority forms. One administrator showed the types of data that were frequently recorded incorrectly. For instance, there is a section on the front page of a specific form entitled 'Assessment of Services Summary Details' (produced for each client) and offers drop-down menu options to describe the client including the following (Appendix 5):



(Interview, Site 1, P110, Administrator, Thursday, 21/04/2016).

According to Callon, drop-down menus serve as inscription tools which help to stabilise networks through standardisation [(249)]. The menus shape data formation, ultimately determining the type of social care provision [(249)] . However, in this particular instance these options were more-often-than-not misinterpreted by care managers resulting in a failed network and unsuccessful translation [(223)]. For example, administrative staff explained that staff would often confuse 'single' with 'shared' and 'comprehensive' with 'complex' options. In this context 'single' refers to a client who is in receipt of a service or services that are not shared with other agencies meaning that they are directly employed and under the control of the local authority. Whereas 'shared' means that a service or services are shared for instance, by NHS or other external or private agencies. Care managers would select 'shared' when in fact a service was 'single'. Misunderstandings seemed to stem from incorrect assumptions that external agencies included meals on wheels, community alarm or domestic services, (operated from different locations) however, these services were employed directly by the council at the time of observing. Additionally, care managers would confuse 'complex' with 'comprehensive' in a similar manner resulting in all sorts of permutations of incorrect

responses which impacted issues such as client invoice production and service use records.

Incidentally, this particular form was the only one that was not recorded electronically by care managers in one particular council. It was not that the IT system lacked the capability, rather that there were repeated examples of incorrect documentation causing confusion. Managers reported the IT system being clumsy which did not help matters. This led to the formal decision to manually record the information and then administrators would upload to the system to improve data quality. Administrators would access client electronic files, crosscheck 'Assessment of Services Summary Details' details against service provision, create an electronic version based on this information and then make corrections to the physical file.

The confusion emanating from this particular form completion was witnessed during observation periods. I asked several care managers if they could explain what the specific options were and what they meant as they did not seem self-explanatory. Many did not know:

> *'I'm not sure what the others mean, I normally use this one', [pointing to one response], (Fieldnote, P107, Social Worker, Tuesday, 15/03/2016) or 'oh, I don't know, I just tick that' [pointing to a box] or 'I just ask [name of senior administrator]. (Fieldnote, Site 1, P105, Social Worker, Thursday, 17/03/2016).*

Other misunderstandings occurred when social workers recorded 'outcomes' on the client management system. Many social workers confused an outcome with care package details. An outcome is designed to capture how a client functions/feels as a result of whatever intervention has been put in place, yet often care package details would be inserted instead:

> *'Some social workers record outcomes as: 'client is now receiving care at home'. That's not an outcome. That's just a service we deliver. An outcome would be; 'they are now supported to live more independently, or they can*

do this themselves.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).

All local authority client recording systems offered drop-down menu options which helped reduce errors, although as previously noted, some options were not self-explanatory which lead to inaccuracies due to a lack of understanding of what each option meant:

'Em, but some of [name of IT system] dropdowns, you know, it's no wonder people get confused with what they should be choosing.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).

During subsequent interviews and observation periods a lack of knowledge held by some staff was queried, particularly with regards to form coding and local procedures. One manager replied with the quotation below. She also acknowledged forms needed to be re-evaluated adding that 900 of the local authority's documents were currently under review:

'People just, people just, em, come in and if they need to know something they'll just ask. And if somebody tells them rubbish, they'll go with it. Em, yeah, I think you've to work here for a long time before you really understand what things mean. [Laughs].' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).

Suchman describes data production as coding processes; a hybrid of objective evaluations, but which then require interpretive judgements (297). In her study with a law firm, 'document production' was organised hierarchically in that as one progressed through the company's ranking system[9], one was required to handle progressively fewer but more specialised and refined document sets (297 p.31). Case building began initially

[9] Document Production, in which business documents (memos, correspondence, financial reports), often numbering in the hundreds of thousands, are taken by a defending firm from the client organisation's files and copies are turned over to the other side. The same corpus of 'responsive' documents then provides the basis for both defence and prosecution. 281 p. 29-45

by junior lawyers who performed mundane tick box exercises guided by lists of master codes intended to help locate company files. The often hundreds of thousands of documents that were sifted and extracted into file stacks formed the basis for the defence and prosecution. Junior lawyers based their decisions on master code sets alongside knowledge of the lawsuit gained from their involvement in the case; including court appearances as well as through direct engagement with clients and opposing counsel. Whilst master codes served as an objective categorising agent, the case worker's experience and history with the case meant document production was also subjective.

Suchman explained that in law firms, following initial coding, cases progressed to a document coder (more experienced lawyer) who sifted through extracted files and applied refined codes on a document by document basis rather than in large stacks produced by the junior lawyer [297]. Knowledge of a case and judgements made resulted from purely objective information obtained within specific documents and also from factual conversations with other coders working on the case. This was in contrast to the junior lawyer's method of direct engagement with clients and opposing lawyers. Suchman observed coding being categorised differently by workers reading the same information. This indicated the application of a degree of skill and judgement where information was reproduced through specific discursive practices rather than from pre-conceptualised objective knowledge [297]. Suchman's study was able to make visible the everyday work of different professional groups and how they used these objects of knowledge [297].

Like Suchman, one could argue that in the social services world, similar production processes were enacted [297]. Form completion was initially conducted by a client's case worker guided by lists of codes and in most cases following an assessment by the social worker who had a clear and contextual awareness of a client's situation. Information was shaped and reshaped by what Sellen refers to as 'knowledge workers' [298 p.51]. Judgements were made through direct interaction with the client, carers, family members, besides health and social care team members resulting in objective and subjective decision-making. This information was transferred to other workers (administrative) who through different knowledge work practice interpreted data

differently. Production of information was often problematic due to categorical differences in terms of which judgements to make. A lack of knowledge and understanding of everyday processes held by care managers when applying coding decisions to local authority forms seemed normalised. Thus, when anomalies were identified, they were attributed to the confusing nature of inflexible IT systems, ambiguous forms and a lack of staff training.

One local authority executive highlighted the need for caution towards some coded information where difficulties were identified and attributed to new operator understanding and meaning of data entries. Subsequent analysis by data analysts operating from different localities could result in misleading and inaccurate findings:

> *'When it can become problematic is when data is used in a way that means people get driven by the data rather than understanding the data and what the trends and the processes are telling you as a result of that. So, I need to know if our, if our delay [discharges] has suddenly started going up; I need to know that. [Coughs], because, I need to work out what we need to do. But if its suddenly going up because somebody's new to the position and has just thrown all this data in and went oh my goodness, as long as I have staff who can look at that and go, well hang on a minute, actually, actually, you know, six of these people who are on that information actually haven't been agreed by anybody that they're delayed. You just spoke to the junior nurse that day and she hasn't actually understood what's going on and these three actually are all there so the actual reality is you need to be worrying about two and not twenty-two. So, it's the bit about how you work with that data that actually makes it worth that or not worth that.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

A lack of knowledge, understanding and meaning of some questions on forms during routine coding actions hindered accurate recording by care managers. Incorrect decision making was exacerbated by cumbersome IT systems, confusing drop-down menu options, ill-defined forms and insufficient training in one particular local authority. New

and existing staff were exposed to a high risk of error making during these recording practices, although inaccuracies seemed normalised over time.

6.5.2. Missing or Incorrect Data

Missing or incorrect data, and files not being kept up to date were common criticisms expressed by almost all social work administrators and data managers. A combination of factors were responsible and these are discussed further in later chapters. However, significant improvements had been made in data quality over recent years largely due to new strategic posts whose role it was to focus around data accuracy through getting to know data meticulously and through screening:

> *'I think it was more to do with [name of strategy manager) coming into post that this moved forward. It's been a work in progress over quite a period of time, data quality. When I started in social work, we had a number of 90-year-old children.' (Interview, Site 1, P103, Social Services Manager, Monday, 08/02/2016).*

A number of different strategies had been developed by all local authorities to control for data quality. For instance, one council created screen 'pop-ups' to prompt care managers and assessors to input omitted data from previously submitted forms. These pop-ups would flash, annoying some staff and so rather than having the intended effect of addressing missing information, members would cancel the flashing image. Administrators mentioned that staff fully intended to update their system, however they would become distracted or interrupted, adding 'everyone's so busy' *(Interview, Site 1, P110, Administrator, Thursday, 21/04/2016).*

Alert systems are used in a variety of industries including health and social care; usually to inform a user that a particular task needs to be performed. Many reviews in the literature comment on 'alert fatigue' where cognitive overload, interruption of work flow and increased frequency of reminders reduce the efficacy of the prompt [(299 p.2) (300, 301)]. From an ANT perspective, record management systems were not passive keepers of information. Rather 'pop-ups' were delegations designed to warn users in an attempt to increase data quality and if used as intended would have resulted in a perfect translation

[251]. Because this did not happen, and under ANT definition, pop-up neglect would be categorised as a failure of the 'data quality' network. However, in this instance the failed network occurred at the expense of other network successes. For instance, staff with competing priorities in complex organisations such as social care ensured best practice in a specific time, place and in context of the situation. This was described by Eric Hollnagel in his research on safeties where he placed an emphasis upon what an organisation does well rather than what it does poorly [302]. In relation to pop-ups, staff adjusted their performance to fit each situation (ignoring pop-ups) and in doing so, were able to maintain conditions to carry out their work, thus ensuring successful networks elsewhere.

Other councils would review data quality on a continuous basis, running system scans for irregularities. Individuals who were frequently non-adherent to expected standards were identified and information regarding anomalies was forwarded to team managers in an attempt to pinpoint reasons and to take action to reform work practice. One local authority produced an audit of all data errors on a regular basis which were incorporated into a spreadsheet and emailed to every member of staff. Errors were itemised by department/locality. According to Flynn, health and social care professionals are required to become more transparent and accountable for performance outcome measurements through 'soft bureaucracy', enabling a more entrepreneurial style of governance [303 p.12-15]. From an audit perspective, data are perceived as explicit encoded knowledge to facilitate organisational control whereby monitoring regulates accuracy, consistency and reliability:

> '*So, if you filed an assessment, we do runs for example, and different other things that we do and so what we know is if you filled question 2a, you should have filled in 2b, c and d. If you filled in just b, that's maybe ok, she should just be going to question 3 next. Cause you're prompted where to go depending on your answers. So, we can run, and we do run and send out regular reports that says, actually these people are missing this in this current assessment, or these people are missing in that area you were filling in last week. And this is your team and this is the people in your team who have not filled that bit in correctly. So, we give them a full like audit report*

of, like an error report. Housing get the same.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).

Staff received the audit which seemed to serve as a performance league table which was eagerly anticipated in one department during observation. Staff would view which department/locality held the fewest/most errors. This management theory approach places an emphasis upon encouraging employees to recognise their individual responsibility for work quality and accountability through driving up competition to improve reliability and standardisation of data quality [(303)]:

'[Name of social worker] showed me the report that is sent by data managers highlighting errors and omissions. [Name of locality social work department] were not on the list meaning their data were correct. [Name of social worker] admitted they saw it as a competition and were very quick to correct any errors that did come to light. This seemed a very innovative approach to police data quality.' (Fieldnote, Site 3, P304, Social Worker, Thursday, 17/08/2017).

Through local authority partnership collaborations, other local authorities adopted a similar auditing strategy to improve the quality and consistency of data.

'We get reports, well not us, but admin officers or the seniors get a report at the end of the month. And anybody that's not go their ethnicity or it address, or local authority or private rent, eh, owner occupier, if that wasn't on the system, you know we get reports so we have to go in and add it. Put it round, ask the worker, could you find out what this person is and then they'd come back and we would update the system. I think its [name of performance manager] that generates all these.' (Interview, Site 2, P201, Administrator, Monday 04/10/2016).

One local authority introduced a comprehensive list of physical and mental health conditions to enable social workers to record health status. However, assessors would not ask clients to divulge each condition they had and instead collected details deemed

appropriate to their care which introduced limitations to collecting this type of data. Reports would not necessarily be representative of overall patient health. The same principle applied to other local authorities who displayed a narrow selection of conditions restricting their range and reliability. Additionally, medical conditions were often held in narrative form in case notes meaning they were difficult to trace during future assessments or audits. This makes analysis difficult when attempting to obtain information about client groups as an aggregate. For example, how many clients had a diagnosis of heart failure or other chronic health condition? Similarly, individual care pathways were difficult to track accurately.

In terms of data quality, one service manager mentioned '*It's a constant battle' (Interview, Site 1, P103, Social Services Manager, Monday, 08/02/2016).* However, on the whole, data was deemed by respondents to be as good as it could get especially with the aforementioned protective measures in place. These data were instrumental in reporting regional statistics to the Scottish government and also in assessing local service planning and use:

> *'So, the social workers assessment of a client goes into profile notes and the drop-down list, it's their assessment of that client. We'll get errors in dates of birth, we'll get errors in addresses and we'll get errors in names. We could have a client called [name of client], and another client called [name of client], and they're separate files but they're the same person. So, then we go searching for orphaned clients and try and join them up again. So, error checking quality wise, it's as good as it can be. I mean we do get errors but this is the learning curve that we go through.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

This opinion was echoed by strategists and analysts working with social care data and views were consistent across districts:

> *'Ok, eh, I'll start with the quality of the data. I think the quality of data has been good in [name of local authority district]. I think they're quite on the ball with regards to that. It has been from what I can gather for a number of*

years and they have quite a bit of prior experience with ISD' (Interview, Site 3, P303, Data Manager, Friday, 11/08/2017).

Data discrepancies and missing data were kept to a minimum through efforts from data managers who developed techniques and tools to aid accuracy, consistency and reliability. Secondment of ISD personnel to local authority offices also helped with data management expertise. Some strategies worked better than others and whilst errors were reduced, the very fact that data input was heavily contingent upon the human element means that errors may continue to occur. In consideration of this, the famous proverbial phrase '*errare humanum est*' 'to err is human' springs to mind, that is; everyone makes mistakes.

6.6. What These Data Do Not Tell Us

Over the course of the project it became clear that although great strides had been made in data collection processes and analysis production, there were however, examples where particular types of information were not captured. For instance, IT systems are adept at producing quantitative measures from analysis but health and social care evaluation particularly from hospital settings seemed to be designed around exception reporting to the exclusion of contextual factors behind these figures. An exception report would identify any event that was outside what would be considered a normal or designated threshold. The following extract focuses on hospital delayed discharges:

'The kinda things it doesn't tell me though and this is the problem when you're doing exception reporting, is you don't always get context that sits behind that. So, for example, I might know of ten people who are delayed today. And that that has gone up by two. So, therefore it's going in the wrong direction, alright? But actually, what I don't know and what the system doesn't tell me in terms of the context of that is to be able to work out a little bit about it. Well ok, we've gone up by two delays today, but actually the hospital has turned over ten times as many people. So, we might have two delays but actually, the reality is we got one hundred people out today. As opposed to fifty people yesterday. (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).

Similarly, other information absent from outputs related to an inability to present measures to enable a complete representation of events as told by one care manager below. Information not only depicted a partial picture but incomplete reporting affected morale resulting in a sense of low professional worth:

> *'So, we might assess somebody, gosh within 48 hours, or in 24 hours. It's not being flagged up that that was really good. That actually X percent of the people coming through who were referred, were seen within 24 hours. The thing that people are checking every single day, social work managers, health managers, ridiculous amounts of people looking at delayed discharges. Nobody is actually saying, your team are doing great, they're seeing people in 24 hours, and they've assessed them within that time. (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

All social care client management systems had the ability to access large amounts of information in order to perform strategic analysis. However, many of the social work client facts, which gave a more in-depth picture of individual circumstances were gathered in narrative form and stored as case notes. Case notes held a wealth of nuanced details but this information could not be used in analysis or be reduced to simple numbers. One council were quite innovative and found a way to overcome specific shortcomings applying pseudo variables to case notes to calculate necessary staffing levels as shown below:

> *'I mean, one of the things we found was about profile notes. [Name of local authority IT system] is quite comprehensive, but they're [meaning social workers] all rubbish at using it sometimes. And the one thing that they all hate doing is stating what time they started and what time they finished with the client [during client visits]. And we never knew how long they spent with a client, and that goes for most systems. It's not that they really think they're hiding anything, it's just they cannae be arsed. They've just got better things to do. They just get profile notes in and then they've got another client to go and see. But what we did was we reviewed all the profile notes for content and we also reviewed the number of profile notes that were raised against*

the client and we saw patterns that we now use for costing.' (Interview, Site 3, P301, Data Manager, Friday 19/05/2017).

Combined health and social care analysis became a prominent feature over the course of the project. Local authorities provided social care data to ISD who matched records to health data for analysis. Findings were returned to local authorities at population rather than individual level, and although extremely useful for overall use and planning purposes, reports made the tracing of individual pathways impossible to determine:

'Not on an individual, a lot of it is just aggregated and it's like. So, 5 people came in and 5 people left but they kinda went on this and that. Some of it, it has been a challenge, trying to look right down to individual level. (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).

Two local authorities offered a limited list of physical and mental health conditions to which a social worker could apply to their client record whilst another district incorporated a comprehensive list. However, neither list presented an accurate reflection of client health since social workers would collect only health conditions pertinent to their case or care package. Additionally, many cases were recorded informally in case notes creating a hidden history of health events or diagnoses:

'I noticed there was no way to indicate some health conditions on the system. [Name of social worker] told me that sometimes they would find out about client's medical issues, but that they might not be told all diagnoses and that the information provided was in narrative form and not contained in any drop-down menu box. (Fieldnote, Site 2, P203, Social Worker, Thursday, 06/10/2016).

One local authority developed search terms in order to locate specific types of information captured in narrative form. And although helpful, findings were only as reliable as the quality input by social workers. For instance, as noted previously workers would only upload what medical conditions they felt were appropriate to client need and services provided, resulting in limited accuracy:

> *'The text you're talking about is the profile notes so we can't really scrutinise. We can pull the profile note and it can search for the words 'long term conditions' so that I'm only seeing notes on long term conditions.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

When uploading information from referral forms, the recording system depicted a field relating to drug or alcohol issues. It was found this section did not apply to clients over 65 years unless they were already under the care of drug and alcohol teams. Such information could send a skewed message if trying to determine drug or alcohol problems in older social care populations:

> *'I just ignore that because it's not relevant to my referral. I take it if it was under 65 team based in [name of locality department office] or a drug and alcohol team, they would probably ask that.' (Interview, Site 2, P201, Administrator, Monday, 04/10/2016).*

Existing health and social care reporting systems were not able to inform on contextual evidence due to exception reporting configurations or narrative reports held in client case notes making a holistic examination unachievable. And although health and social care data were successfully linked to provide a valuable examination of local population activity and use, individual client health and social care pathways could not be evaluated. Additionally, specific information such as medical conditions were collected arbitrarily and uploaded to social care records on an *ad hoc* basis, meaning any analysis had to be accepted with these limitations in mind. Health and social care data linkage is in its infancy, but could prove instrumental in addressing discrepancies in information collected, particularly medical conditions and other information not presently captured by social care.

6.7. Communication

During 'translation', Brown describes the process as communication; messages that pass between points 'communication is good, whilst miscommunication is at best an error or at worst a disaster' (as in 'communication breakdown') [(304 p.7)]. There were numerous occasions where effective communication between social care and other agencies was

identified through witnessing smooth and swift client care pathways in both community and hospital settings. As Callon notes, they are simple intermediaries passing through a network, performing as intended, sharing space in harmony; considered aligned and a 'perfect translation' [223 p.145]. Breakdowns in processes also occurred and had it not been for local rapport in many instances, these collapses in operation would have been exacerbated. One unfortunate incident led to the inappropriate discharge of an elderly gentleman, who before admission to a community hospital was receiving tailored social and palliative care. Social care were not informed of his admission in the first instance. Then through OT error he was discharged under Immediate Discharge Service (IDS) and without the pre-arranged care being re-instated. The client's case manager only became aware of the event through viewing her management system the following morning and noticed the flagged IDS discharge. Care was adjusted promptly, and given the client's prognosis of just weeks rather than months to live, meant he did not suffer adversely.

Successes and failures in communication occurred across all regions. For example, all local authorities contracted private care providers, as well as locally employed carers, providing community or residential/nursing care services. Sites 1, 2 and 3 contracted 11, 10 and 11 independent care providers (respectively) at the time of writing. Local authorities were consequently in daily contact with most providers. Some local authorities permitted companies to cease or reinstate services following admission to, or discharge from hospital. Other local authorities insisted on social work being contacted before alterations to care packages. It was unsurprising then to see that in hospitals which covered a wide range of local authority districts (all with different policies), services sometimes commenced without prior knowledge of social work:

> *'Whilst observing it seemed communications between private contractors, hospital staff and service co-ordinators were heavily dependent upon the relationship developed. [Name of service manager] gave me a few examples. Last week she received a telephone call from a private care provider saying 'Do you know Mrs X has been discharged?' But of course, social work had not been informed contrary to local authority policy. It transpired that ward staff at [name of hospital] contacted the care company directly to recommence a service rather than getting in touch with social work. It*

> *appeared that some ward staff were not aware of correct procedures as some continue to contact care companies directly. [Name of service manager] and the care company manager had built a strong rapport over many years therefore co-operation and communication worked well. [Name of service manager] envisages future difficulties particularly in view of the recent and rapid growth in privately contracted care companies who may be less familiar with proper procedures. Like she said, 'not all new companies will be familiar with everything and relationship building takes time.' (Fieldnote, Site 3, P304, Social Worker, Thursday, 17/08/2017).*

There were instances where poor communication resulted in confused, conflicting and sometimes alarming outcomes. One such event involved a series of incidents involving contradictory interactions which when examined exposed the fragile nature of managing complex situations between multiple agencies. The following extracts are fairly lengthy but they are reported to illustrate successes and failings in communication on several levels throughout one particular situation. Through ANT, the flux of realities and multiplicities were identified helping to conceptualise how changing networks are a continual process in context, and contingent in how realities and experiences are enacted by different actors. This section offers some background to the case from field notes:

> *'[Name of client] is 96 years old, lives alone and is in receipt of privately funded homecare visits. The client's only two daughters live abroad and arranged personal care due to their mum's increasing frailty and their concern with distance. One of the daughters made a scheduled visit to her mum's over Easter and was appalled by her condition. [Name of client] was in a lot of pain, her bottom had broken out in sores, she had lost weight, was unclean and smelly. The daughter called the doctor immediately and told the care company not to come back.' (Fieldnote, Site 1, P105, Social Worker, Wednesday, 30/03/2016).*

This initial portrayal highlights two fundamental failures. First, the care company who incidentally were also contracted by the local authority failed in its duty of care to report a deterioration in health of someone under their charge. Second, this 96-year-old lady

qualified under Scottish policy for free personal care. The care company and the GP practice failed to notify her or her family of this provision. Both daughters had lived outside the UK for many years although they visited as often as they could. They did not know about this complimentary care and were upset when they were told through subsequent social service visits. The next section describes how the case progressed and shows an excellent example of person-centred care involving multiple agencies delivered in a timely manner:

> *'The doctor arrived to find [name of client] dehydrated and there was a question mark over whether she had suffered a stroke or Transient Ischaemic Attack (TIA) or mini stroke as it's more commonly known. The doctor recommended admission to hospital, but the client was reluctant to go. Concerned for her mother, the daughter called her sibling who booked the first available flight to Scotland. Since the client was tentative about being admitted to hospital, the doctor referred her to the Early Intervention Specialist Nurse Team who then referred [name of client] to the social work Enablement team for further support. Between the daughters' care and efforts from health and social care teams over the next two weeks, [name of client] improved. Both daughters stayed with their mother throughout this time but were concerned with recurring episodes of what they thought were TIA's especially as they had to return to their respective families soon. It should be pointed out that one of the daughters is a practising registered nurse. (Fieldnote, Site 1, P105, Social Worker, Wednesday, 0/03/2016).*

The care manager under observation was duty manager one afternoon. She received a telephone call which illustrated the flow and co-ordination of communication during the above case and the changing networks between multi-agencies during joint working as follows:

> *'[Name of social worker] took receipt of a telephone call from a relative who reported the possible cancellation of an Enablement Review meeting which had been arranged for the following morning. The caller talked about worries she had over her mother who was experiencing frequent TIA's. She called the doctor who paid another house call and who concluded that the*

client should be admitted to hospital. On this occasion, the client agreed and the family were waiting for news regarding a bed at [name of hospital]. [Name of social worker] contacted the Early Intervention Specialist Nurse and Enablement Team to warn that the review appointment may not go ahead and that she would contact them first thing in the morning with the latest news. (Fieldnote, Site 1, P105, Social Worker, Wednesday, 30/03/2016).

The case evolved and the review meeting went ahead as the client was still waiting for a hospital bed. This extract shows a breakdown in communication as conflicting events unfolded causing an air of tension and a strained atmosphere altering network dynamics:

'The early intervention nurses and enablement team were already in attendance and acquainted with the client and her daughters. [Name of social worker] described her knowledge of the case explaining that she only became involved as duty manager and asked for an update from the nurses in terms of the client's pending admission to hospital. The nurse informed everyone she knew nothing of any admission to hospital. 'People aren't admitted directly into [name of hospital]. They may be transferred from a ward in another hospital, but I've never heard of a direct admission'. There was a sharp and feisty edge to her voice whilst also appearing somewhat dismissive. In response, the daughter defended her statement: 'Well, I'm only going by what I was told'. [Name of social worker] asked the nurse if she could obtain further information from the doctor in terms of what was happening with the client. The nurse left the room and used her mobile phone to call around. The doctor who attended was off duty, the doctor's secretary could not find any notes on the electronic system to indicate admission, and the hospital in question confirmed no admission was scheduled.' (Fieldnote, Site 1, P105, Social Worker, Thursday, 31/03/2016).

The previously convivial atmosphere changed and there was an air of frustration from the daughters and what seemed resistance from the nurse to accept what the daughters

had told them. Trust appeared compromised as the daughters later divulged they felt they were being accused of being dishonest:

> *'Further [and what seemed unnecessary] statements from the nurse intensified rather than ease matters. 'I don't believe a doctor would admit direct to [name of hospital]. 'I've never heard of that happening so why would a doctor say that?' Which encouraged comments from the daughter 'I live in [**name of country**] I don't know **anything** about the wards or ward **numbers**, so how would I be able to tell you if the doctor didn't say it (emphasis in the original)?' Also, as the meeting progressed, the nurse kept going back to what the doctor may or may not have said. The song from the movie 'Frozen', and 'Let It Go' sprang to mind as in my opinion, going over and over the matter served no positive purpose.' (Fieldnote, Site 1, P105, Social Worker, Thursday, 31/03/2016).*

After examining the client, the nurse was satisfied the client did not require admission to hospital, however her manner to justify this was rather flippant and unsympathetic:

> *'The nurse stated the situation was not a medical issue but rather a social care matter but further added: 'I can put pressure on people to get [name of client] admitted, but she'll probably be discharged the following day as she's in better health than the majority of people I see.' (Fieldnote, Site 1, P105, Social Worker, Thursday, 31/03/2016).*

In what seemed an attempt to bring some calm to the situation, the care manager steered the conversation to bring about a suitable and agreeable outcome:

> *'[Name of social worker] suggested that until events were clarified and as an interim measure, arrangements could be made for mum to go into emergency respite until the family and mum decided a way forward. The daughters agreed to have the discussion with mum. The meeting concluded on that note and as soon as the care manager returned to her office, she immediately reported events to her team manager. Measures were put in*

place to prepare for emergency respite. On reflection, I considered everyone's point of view. On one hand, the daughters were understandably angry and frustrated at finding their mum in a state of neglect, then being told she should not be paying for her personal care. And as if to add insult to injury was the news of an imminent admission to hospital, only to find out that no such event was planned. On the other hand, I felt the nurse could not confirm or refute the doctor's account putting her in a rather untenable position. However, instead of moving forward and making the best of a poor situation she was reluctant to accept that a GP would make such a statement and became somewhat transfixed by continuing to doubt the daughter's account. In the meantime, the care manager and enablement team seemed caught between two fires. I thought about the mismatched communication between the GP, nurses, social work and family which ultimately turned out to be the basis for contention. The consequence of which neither corner were happy with the outcome. The daughters were upset, 'I feel mum has been let down'. The situation made me think about articles I had read in relation to health and social care studies where over decades poor communication has been highlighted as a key contributing factor to unsuccessful outcomes. Despite the number of times this statement is published, poor communication continues to rear its ugly head with seemingly no apparent solution – other than the need for improvement. Is this study going to add to these masses, I thought?' (Fieldnote, Site 1, P105, Social Worker, Thursday, 31/03/2016).

Communication lies at the heart of the caring process and the examples given demonstrate the complexities in everyday, real life settings when co-ordinating client care involving multiple agencies, policies and contextual information. Whilst policies can guide action and best practice, care management systems and the human element are visible as both enablers and inhibiters of good communication.

6.8. Expectations

Throughout the study period many participants referred to high expectations from members of the public which became a recurrent theme. Others mentioned health and social care staff expectations where some were unrealistic whilst others were products

of contractual requirements, professional values or technological advances. For instance, some service managers saw an increasing trend in client and family demand for services in an idealistic rather than realistic manner. There appeared to be a number of reasons as outlined by one assessor:

> *'[Name of social worker] felt that families had various reasons for high expectations. 1. Some felt they had paid into the system through their taxes over the years and were entitled to whatever help they requested. 2. Others felt it was social work's role to look after their family contrary to years gone by. 3. Some family members were spread over the country or lived in different parts of the world where concern for their family was intensified by distance.' (Fieldnote, Site 2, P206, Social Worker, Tuesday, 20/06/2017).*

Social workers felt some families did not understand the role or responsibilities of social services or who seemed to take advantage by insisting on unnecessary tasks as voiced by one social care assessor:

> *'[Name of social worker] told me it was very common for families to request social work to check on family members even when the people concerned were at home and able to pop round themselves. She felt that the public needed to be educated to understand the role of social work. [Name of social worker] also added that she felt social work was constantly being perceived as a 'babysitting service' rather than a personal care provider.' (Fieldnote, Site 2, P206, Social Worker, Friday 14/04/2017).*

Staff from every local authority gave numerous examples where families would often become abusive or threatening to social care staff. The consensus of opinion centred around younger generations or the most informed of society as being the most demanding whilst older generations or those less versed tended to be more yielding:

> *'I think they feel the pressure and I've spoken with newly qualified workers and in fact even somebody who's been about 4 years qualified and has just recently moved into a team leader post. And both of those workers were*

equally expressing em, I suppose some distress around pressure that was being brought to bear on them by family. Em, and fighting that. And some of that can get to the point of being abusive, or you know, having to deal with abusive calls and very angry and distressed people.' (Interview, Site 2, P302, Social Services Manager, Monday, 29/05/2017).

There were no shortages of examples. Some instances were a consequence of belief patterns in that after a certain age, one should be entrusted to a care home as a matter of routine irrespective of health and mobility:

'One family contacted social work asking for their father to be admitted to a care home. [Name of social worker] was tasked with assessing the client. The gentleman in question was already receiving a small package of care twice per day. Immediately, [name of social worker] was surprised at the rapid escalation from a small provision to the need for a care home admission. She duly met the 95-year young man who was physically and mentally well with good mobility. [Name of social worker] could find no reason why a care home admission would be required. On telling this to family members, they answered 'but my dad's ***95****, he should be in a care home (emphasis in the original). The man succumbed 'well I am 95, that's what happens'. The family's reason was based purely on his age; a mind-set which seemed to blinker the fact that he kept well and could do almost everything for himself in his own home. (Fieldnote, Site 3, P308, Social Worker, Friday,* 18/08/2017).

Some requests for care bordered on the peculiar as illustrated below. This particular client may have benefited from other social activities to address potential loneliness, however, the family were unwavering on the request below:

'When [name of social worker] was explaining this to me, [name of Access Team colleague] who was sitting across the desk-space overheard and said 'oh, do you remember the man who wanted company to cut the grass?' This 85-year-old man was totally independent. He and his family became upset

> *when they were told he did not meet the criteria. The family retorted by saying 'my dad **fought** for his country, **paid** his taxes all his life. **He's entitled** (emphasis in the original).' (Fieldnote, Site 3, P308, Social Worker, Friday,* 18/08/2017).

It was not only clients and family members who placed unreasonable expectations on social services. Other professionals with different values and practices were amongst frequent requests for unwarranted provision under social care policy. For example, social care principles believe in doing with rather than doing for when working with clients:

> *'A district nurse called social work and requested social care services as the client's home was dirty. The nurse, although well-meaning was not willing to accept client choice. Additionally, [name of social worker] mentioned the nurse was reluctant to chat to the client about the cleanliness issues. She added that the nurse refused to air the subject and regarded the task as the role of social work despite joint working and the fact she was on site and could have addressed the issue in tactful manner there and then.' (Fieldnote, Site 3, P308, Social Worker, Friday, 18/08/2017).*

Other professionals were inconsistent with local knowledge and referred clients to social services with mistaken information leading to client expectations being thwarted:

> *'[Name of social worker] said some professionals 'sell' social services incorrectly. For instance, one mental health officer said to a carer 'go to social work, they'll give you respite vouchers', when in fact this information was totally inaccurate. This led to family expectations being regrettably dashed.' (Fieldnote, Site 3, P308, Social Worker, Friday, 18/08/2017).*

Some clients had low expectations and these were generally expressed by older generations where there was often a reluctance to request or feel deserving of services:

> *'[Name of social worker] also mentioned alternative experiences when she provided services to people who did not know the availability of or who did*

not think they would qualify. One such case was a 103-year-old lady who was in receipt of a small package of care. However, [name of social worker] felt the lady was isolated and asked her if she would be interested in taking part in some social activities. Her service was increased to include a one-day placement per week at the local day centre. The lady was 'over the moon' and very happy as she did not think she merited the service. (Fieldnote, Site 3, P308, Social Worker, Friday, 18/08/2017). Similarly, an elderly couple were having a new heating system replaced including a new boiler, pipework and radiators. They were not expectant, but delighted when [name of social worker] offered respite whilst the work was being carried out. (*Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).*

Corporate expectations were also a matter for concern. Social workers felt that some residential and nursing home companies viewed local authorities as easy targets to obtain additional funds through requests for payments for additional staff or by transferring a client from residential to nursing care provision. This meant social workers became reluctant to place some clients in specific care homes for fear of consequences further down the line. Instances such as the one below was witnessed on more than one occasion during observations:

'*She told me she found dealing with some organisations who offered both residential and nursing homes facilities particularly challenging. One of her clients was assessed as in need of residential care and was accepted into a home [following the care home's own assessment]. The care company contacted social work in subsequent weeks requesting a further assessment to include nursing care. Her client's needs remained the same, however care home staff insisted on nursing fees. Some companies even told families to remove their family member if they could not come up with additional funds adding unnecessary stress to clients, carers/families and additional workload to social work staff.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).*

Expectations were high in terms of the possibilities technology brought. However, some social service IT systems were developing and on catch-up compared to other regions or organisations. Never-the-less there was a belief in the public domain that cutting-edge technology had already been established:

> *'And, it, it becomes difficult to prioritise the leaps ahead that you need to make in order to keep up with the kinda data expectations which are out there nowadays. So, we, we've got gaps in how we collate, in fact in some cases we're manually collecting data, which is not a good use of peoples' time.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

In a similar vein, some staff felt technology influenced public expectations in terms of speed of functioning as mentioned by one manager:

> *'We talked about technology and the effect it had on her work and [name of service manager] said something very interesting. She said 'the ability of technology influences our expectations' meaning that because computers work at a speed beyond human performance, there was an expectation for humans to function at higher level which she did not think was a healthy outlook. (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

On reflection, it seems high expectations expressed by the general public, other professionals and corporate entities show how the demand for services are out of kilter with social service criteria, professional ethos and available resources.

6.9. Decision Making

Social workers are required to make judgements based upon knowledge and understanding of situations often gathered from multiple sources with many intricate layers. Finding out how decisions were made and what factors influenced the decision-making process led to this next focus. For instance, making judgements involves strengths, interests and motivations that social workers bring to a situation and which

will vary between staff members as will values and previous experiences [305]. Awareness of what different professionals can do can bring a further dimension around decision-making [306]. Drawing on peoples' networks and the community can inform workers in new areas, making judgements around support more appropriate to person-centered care. All these processes through which a social worker deliberates over a way forward with a client was rather elegantly described by one service manager:

> *'I suppose a range of things. What does risk look like in terms of different client groups; what's the evidence base and how we understand models of risk assessing. Also, how do we get into looking at personal values, social work values, and looking at ethical practice and bring all of that to bear and the evidence base of how we understand human condition and development across the life span. And bring all that to bear on decisions em around either when to intervene, how to intervene, and other major issues around that can impact whether a child stays at home, whether an older person is deemed to have capacity, and those kinds of decisions that can em impact where people are and where they're living and their you know, the sort of levels of support being given to them. (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

During observations and by the time an assessment was concluded and uploaded to respective IT systems, many questions had already been asked to help with the decision-making process. The following extracts describe how different social workers appraised knowledge during different scenarios. A selection of situations are presented to outline different mechanisms to bring about decisions. For many social workers local team or community MDT meetings were often a source of help during decision-making. Workers would discuss quandaries as the following extract demonstrates:

> *'Nurses mentioned the patient was very demanding and often became angry. [Name of social worker] also found out he was furious at not being allowed to use his shisha pipe when he was on the ward. [Name of social worker] talked through her concerns. The team meeting helped [name of social worker] in her decision-making of this tricky and sensitive situation. [Name*

of service manager] suggested that when visiting the client in future she is accompanied by another member of staff.' (Fieldnote, Site 2, P206, Social Worker, Tuesday, 18/04/2017).

More often than not, social workers would make decisions involving other professionals to support or to offer alternative views or options as this assessor did. The following extract involved the decision whether a client required care home placement on a permanent basis. The client had been diagnosed with Korsakoff's syndrome resulting in severe memory lapses, a condition typically caused by excessive alcohol consumption, although other disorders can cause the disease:

'[Name of client] was a small framed chap who looked healthy and seemed a normal weight for his height at 69 years. He looked smart and well-groomed, wearing a spotless collared shirt, sweater and trousers. He was articulate, polite, and quite charming - he offered both [name of social worker] and I his chair and apologised that he couldn't offer us a cup of coffee. His room was cosy, and it was interesting to see all his personal belongings displayed in a meticulous, orderly fashion, almost military like style. [Name of social worker] asked how he was and he said he was fine. 'Nothing wrong with me, I'm ok'. She further asked if he was settling in ok and he said that he was. He mentioned that he'd go down stairs and have a chat with some of the other residents and if he wasn't doing that he was happy to stay in his room and enjoyed reading a book or doing crosswords. He said he hadn't been outside since he arrived two weeks ago. [Name of social worker] asked if she could ask him some questions, some of which might be very personal. He said he was happy to answer these. She asked a plethora of questions in terms of the history to his case. [Name of client] was forthcoming with information, answering questions with confidence and ease. [Name of social worker] also asked questions about his personal care abilities, activities, feelings and thoughts. The assessment lasted about an hour and a half. She thanked him very much for helping her and asked if he would mind if she popped in again soon. [Name of client] agreed to this. (Fieldnote, Site 1, P102, Social Worker, Wednesday, 03/02/2016).

As it transpired, details provided by the client were in stark contrast to events told by medical staff, staff at the care home and family members. For example, the client lived with family before admission to the care home where his lifestyle was very chaotic. He drank excessively (mostly whisky) and was being exploited (financially and emotionally) by other local alcoholics, prostitutes and drug users to the point where strangers were visiting his family's house every day (and night), being intimidating and causing upset. According to the client, he said he felt in good health and was happy to return to his family home. Everyone else believed he was too vulnerable to live in the community given his susceptibility to mistreatment. The example highlights the importance of accruing as much information as possible from multiple sources in order to make appropriate and safe care judgements.

By far the most common process to help in decision-making was through using instinct or gut feelings in conjunction with knowledge of the local area and information gathered from case history notes, family involvement and other health professional input. These factors have been identified by Gabbay and LeMay in their book which discusses evidence-based practice/practice based evidence [307]. They applied the term 'mindlines', to routine day-to-day practice in clinical decision-making which relied upon collectively internalised tacit knowledge built on initial training and further experiences, alongside formal and informal interactions with trusted colleagues. These combinations are exercised in a pragmatic manner which evolve and continue to develop, change and adapt to different contextual settings over the career span. In a similar vein, Collins and Day observed how social workers tried to avoid using the word 'gut feeling'[308 p.31]:

> *'I remember research that was done a long time ago…and one of the things that came back was don't ignore gut feeling, because it's often not gut feelings. It's often based on something…And if you tease it out it is evidential, it's about not ignoring it but I think it's about not calling it gut feelings because when you think about it there are indications. Even if it's not hard evidence there are indications there that something's not right. You say your gut feeling but if you sit down and analyse your gut feeling it's coming from your experience, your training, your knowledge, and your information it's obviously something* [308 p.31].

The following excerpt is how one social worker talked about decision-making; consistent with the literature [305, 308]:

> *'Later I asked [name of social worker] how she makes a judgement about a client from the information she gathered. She told me it was a skill she acquired over the years and also, she learned to listen to her instinct which she said never failed her. For instance, a client might say they were able to get dressed themselves but through further exploration she would find out this would take over 3 hours to achieve on their own. Conversely, in the past she had reports stating poor mobility in a client but on visits they would answer the door swiftly showing no signs of debility and demonstrate other skills to support this view. Additionally, she mentioned how [name of town] was a small place where everyone knew everybody else. She would be given information about a client being totally house bound but would see them walking down the high street. (Fieldnote, Site 2, P206, Social Worker, Tuesday 18/04/2017).*

The length of time served as a social worker and the level of knowledge and experience gained of a locality were significant factors involved during decision-making. This meant newly qualified social workers or recently appointed staff to a new district would often propose different solutions to similar situations:

> *'It was about looking at particular patterns in decision-making between different cohorts, and I think for me, it might be more to do with you know, perhaps it's more around the differences around students or newly qualified workers not knowing enough about the resources and the local community. So, their recommendations might look different to those of a worker with experience who can be quite creative because they're very involved in their local community, and can see and can kinda be a bit more creative about that.' (Interview, Site 2, P302, Social Services Manager, Monday, 29/05/2017).*

A wide range of clients were introduced throughout observation periods, living in diverse circumstances. Some family members presented forcefully to the point that one came to appreciate the strong sense of character a social worker needed to manage often formidable situations. For example, some families would use intimidating language or tried to browbeat social workers into agreeing services despite being inappropriate to care need and contrary to local authority policy. Most social workers handled these situations with great resolution. There were occasions however, where some would come into conflict with family wishes. The worker would make a decision based on information accrued but then fail to follow through. One care manager was enlisted to help repair a breakdown in service agreement between a care company, the family of a client and the social work department. The original social worker originally assigned to the case became overwhelmed by the conduct of the client's family. The following extract helps to illustrate multiple social realities of a social worker (network) which can influence the stability of a larger network and its subsequent disintegration through failure during the translation process (227). Punctualisation occurred due to the introduction of a different social worker to the network which reshaped and reassembled as a different network. In this case, successful translation followed, leading to the re-negotiation of schedule and provision of social care (249):

> *'[Name of social worker] explained the case further saying that the previous care manager had been coping with her own Mum who suffered from dementia and who had recently died. [Name of social worker] suggested that because the loss was still raw, the care manager let her personal experience influence her professional judgement. [Name of social worker] said that the care manager had confessed to her line manager that she was probably 'too soft' with the family. [Name of social worker] commented later, 'in all fairness, she did what she thought was right but the family manipulated and exploited the care package to an unacceptable point'. (Fieldnote, Site 1, P105, Social Worker, Monday, 14 03 2016).*

Even when decisions were agreed between the client, their families/carers, clinical and social care staff, provision was not always straight forward. Having gone through the lengthy processes of selecting, applying and being accepted to a care home, some

families were subsequently let down as care homes then reneged on their offer of residency.

> *'When thinking about clients, and thinking about other care home visits, it seemed some establishments' cherry picked clients. When I asked [name of social worker], she confirmed this. She said that because of the high demand for care home placements, companies can pick and choose who they want to accept, and not necessarily from a client priority or needs perspective. Rather, it seemed the path of least resistance. [Name of social worker] found out later that one of her client's application had been rejected despite the home initially assessing and accepting him and despite the care home having all the facilities to meet the client's needs. This made me feel very unsettled to the point where I wanted to challenge certain companies on their decision-making processes.' (Fieldnote, Site 1, P102, Social Worker, Wednesday, 03/02/2016).*

Decision making is an individual and collective practice in health and social care. A social worker draws from multiple sources to make judgements from a person-centred, risk versus harm perspective. Service length, individual knowledge and experience impact reasoning where provisions are allocated through negotiating difficult power relations, family dynamics and available resources to achieve satisfactory outcomes that meets policy directives.

6.10. Summary

Key factors from themes associated with data collection processes during social care service assessments and care provision of older people have been presented. The chapter shows that all local authorities followed legislation and government guidelines set by the Public Bodies (Joint Working) (Scotland) Act 2014 to deliver social care services in Scotland. However, each authority developed local procedures and forms to achieve government directives. Clear factors that enabled and hindered health and social care integration became apparent including gathering processes; access to and sharing of information; duplication; data discrepancies; communication and decision-making practices. The methodological contribution of ethnography and theoretical frameworks employed enabled a triangulated view of how formal guidelines are inextricably

intertwined with informal learning and previous experiences in the context of different regions and settings. A series of strengths and weakness of data processes have been portrayed offering a clearer insight into routine procedures and practices. Having arrived at a comprehensible view of data processes, the next chapter examines factors that influence information processes from information technology systems perspectives.

7. CHAPTER 7. THEME 2 – INFORMATION TECHNOLOGY (IT) SYSTEMS

7.1. Introduction

Key factors from overall data collection processes were the focus of the previous two chapters which examined how information materialised and was shaped. This chapter now focuses on the same mechanisms to report factors that influenced the origins and ongoing development of information processes from an IT systems perspective. In order to understand how social care data flows within social care and across other agencies, it is important to understand the role of IT systems within these processes. The chapter describes the technology adopted by each authority and brings together seven sub themes that emerged during the course of analysis; systems performance, systems upgrades, systems development, disparate systems, systems inter-connectivity, systems security and finally, systems reliability.

Electronic systems in social care are core structures in local authorities and are integral to ambitions to improve the safety and quality of services to people in a cost-effective manner. Social services use a wide range of technologies with different capabilities characterised under the umbrella of IT systems. IT systems are the vehicles that enable information to come together in order to achieve social care aims. Social care services were studied to discover how IT systems operate to enable information to flow within social care and across the health and social care landscape from a social care perspective.

7.2. Social Care IT Systems in Use

Electronic packages used by local authorities varied in design and operation. All districts under study employed a client case record management system as their primary IT system. Each system was linked with supportive layers of technology to allow users to interact, explore and analyse data. Other forms of IT included telecare (also known as community alarm systems), real-time homecare roster monitoring systems, and an assortment of individual electronic motion sensors and medication dispensers to gather and evaluate information. The following section discusses client record management systems.

7.2.1. Client Record Management Systems

Each local authority operated a different client record management system however, all were supported by separate business intelligence software to provide reporting, performance management, planning and analyses. Typically, client record management systems held names, addresses, telephone numbers and email addresses of all clients and their next of kin. Client status in terms of personal, medical and social circumstances alongside assessment details and current service provision were also documented. Similarly, information relating to specific queries or requests for services a client or their family/carer/health/social worker may have made, or events that occurred whilst under social care, were held in individual files as case notes. Supporting software packages enabled data managers and strategists to pull information from client documents either as individual entities or in aggregate form to help inform service activity, use and planning.

Site 1 operated their own in-house developed system, tailored to local need, managed and upgraded by the local authority IT department. Hailed as innovative and intuitive by the Scottish government when first installed,[309] its core technology was now out of date making the potential for upgrade inefficient, expensive and inordinately time consuming. Council delegates were in the process of commissioning a replacement off the shelf branded system but during the period of research, the existing in-house system was the focus. Site 2 operated a well-known proprietary case recording and management system which had been in operation since 2007. The software platform currently had over 110 UK district councils under contract [310]. An account team, support desk 24/7 and other professional services were provided which were renewed annually on a rolling basis. Upgrades were developed by the software company. Site 3 also operated an off the shelf, ready-made system contracted by nine other Scottish local authorities but was different to Site 2 [311]. The system was purchased and installed during 2005 and had recently been upgraded to its existing version where it was managed by the local authority business systems team. Maintenance and upgrades were provided externally by the development company but jointly co-ordinated and supported through the local authority business systems team manager. The contract was renewed every five years.

7.3. Systems Performance

There were many comments referring to client recording systems from a range of perspectives. Different patterns emerged in the type of remarks expressed between those working at the front line compared to data managers and strategists and these views were consistent across the three fieldsites. Staff working at the coal face were more concerned with the day to day workings and performance of systems whereas data managers and strategists tended to talk about strengths and weaknesses of systems from a data linkage and analysis point of view.

In the context of the wider study, these different viewpoints were unsurprising. For example, social workers and administrators seemed to accept as a given that computers made work simpler, speedier and more reliable therefore, comments were almost always as a result of systems not performing as expected. Data managers and strategists on the other hand were more accepting of flaws and limitations but whose focus was directed to future enhancements and sharing opportunities in order to become more efficient, consistent and interactive. There was also an awareness of the complex landscape between joint health and social care IT systems where negotiating processes to overcome even simple problems were highly complicated and these matters are now discussed more fully.

7.3.1. Front Line Staff Perspectives

Front line staff and administrators made numerous remarks about IT system functionality. One site was very complimentary of system speed, functionality and flexibility. Another site felt their system did not have the capability to perform what they referred to as basic tasks. However, it has to be pointed out this particular authority were in the process of commissioning a new IT system and views were based on the knowledge that the new system would address these weaknesses. Efficient ways of working were hindered through lengthy and disconnected systems procedures. In ANT, actants (human and non-human) are metaphorically persuaded to co-operate within a network and in the case of this study, encompassed a variety of people, texts, machines and organisational structures enacting specific roles to form a working whole [(245)]. However, if resistance is detected (such as system malfunction) possible modification or disintegration of the network can occur which can lead to an unsuccessful translation

(the process where one thing passes through a network, and does not act as intended) [227]:

> *'Em, but if there was ever a change [to a document], they would have to go in [to the system] and update it and print off a new copy. Em, and it often goes between teams, so it could be, it could be with em, the care management team, and then the person goes into a home, it goes to the review team, em, so you would be looking to transfer electronically and files just now aren't transferred electronically. You get the bundle of papers and they're actually physically handed between teams.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

This fault-finding type of comment was echoed by staff operating much newer systems that had greater functionality. Remarks of slowness in operation or issues with systems crashing on a regular basis were common statements in this remaining local authority. Attempting to complete tasks became problematic causing an inability to co-ordinate services in a timely manner:

> *'**Very slow**. Yeh, some Mondays you can't get in, or the system will crash so that can cause problems (emphasis in the original).' (Interview, Site 2, P202, Administrator, Tuesday, 04/10/2016).*

Poor system performance was not confined to the case management system in this particular authority. Other process such as staff travel expenses had to be submitted to specific links but as the following extract illustrates, this was not addressed satisfactorily leaving workers feeling insignificant and undervalued. The excerpt is just one of many narratives told during the study, in what Dingwall referred to as exchanging 'atrocity stories', a concept to remedy inclusion and exclusion problems that may arise between professions and which define colleague groups [261 p.29]. This story telling is often used to unite a group through the sharing of common problems. It is important to point out that Dingwall warns of the term in that it should not be used to mislead readers into thinking that 'some disaster must necessarily lie at the heart of the story' [261 p.42]:

> *'Our discussion progressed and I asked for their views and experiences of IT. Both burst out laughing, and I got the sense it was out of frustration*

> *rather than anything else. They said the system went down at least once a week and when it worked, was very slow on a regular basis. [Name of social worker] showed me the system to which they have to log their mileage. Most social workers complete their travel logs as they go so as not to have a mammoth task at the end of the month. [Name of social worker] had not been able to access the link since 25th May [4 weeks]. She showed me the emails she sent to IT highlighting this where she felt the response was less than adequate. First, the IT department instructed her to get in touch with another department [out-with the council]. She did this and was then asked to try another PC, or other device i.e. tablet. She also did this, but unsuccessfully. This external link further suggested she keep trying via other devices. She did this again and again and again, but was unsuccessful. She demonstrated the fault to me on her PC and true enough the error message came up. She printed a copy of the email trail for me. The local authority IT department acknowledged the error number and said they were working on it, but 4 weeks later the issue remains unresolved. (Fieldnote, Site 2, P207, Social Worker, Thursday, 22/06/2017).*

Views of systems performance at this level of operation ranged from staff satisfaction to irritation at poor levels of functionality. Older systems were least compatible with network flow and electronic capability which frustrated front line staff. However, even newer systems were not without shortcomings, adding additional burden and staff resentment in already busy and stretched departments.

7.3.2. Data Managers and Strategists Perspectives

There was an air of optimism from data managers who were driven to develop new and improved ways of working to enable previously disconnected staff more access to vital information and to improve systems performance. Health and social care partnership meetings combined with inter-agency collaborative projects helped with sharing new and innovative enterprises. Consequently, data managers increased connectivity to IT systems which assisted social workers to become more immediately informed which expedited work flow and helped in decision-making during crises events as well as everyday occurrences:

> *'Well, that's what I said, the out of hours is the funny one, 'cause they're sometimes not near systems, they haven't got access to [name of local authority IT system], you know so we have to set up different things for them for out of hours. But that's the project we're on with just now, getting all that data. In fact, it might be on the go now. (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

Some staff made reference to IT systems having wide-ranging capabilities however, they acknowledged a lack of expertise as only a few people knew how to use the system to maximise its potential:

> *'I think it goes back to, they don't know how to pull the information out of [name of supporting software system]. Because there are only, very few people that have that know-how to use [name of supporting software platform]), the reporting, um, software that we use to pull information. There're actually very few people that know how to use [name of supporting software platform], and know the background tables, um, so although they might pull the information, they don't know how to get it out. (Interview, Site 1, P104, Data Manager, Monday, 29/02/2016).*

Health and social care partnership meetings and other inter-agency collaborative projects opened dialogue that facilitate the exchange of new initiatives across the three district councils under study. Local authorities were able to pioneer new ways of working to improve systems performance which was greeted with enthusiasm by data managers and strategists, despite acknowledging some system weaknesses. There were areas where a lack of expertise sometimes hindered progression, but again collaboration with other district councils and external agencies helped improve this. These views were in contrast to front line staff opinions who were more critical of systems performance in one particular authority, and this is worthy of further exploration. When reflecting upon experiences between the two domains (data managers and front line staff), some aspects emerged which might help explain the difference in attitudes. For example, social care staff operating at the front line were not generally involved in strategic meetings or systems initiatives. Additionally, they collaborated with other disciplines with a focus on care co-ordination rather than paying attention to intricacies of IT systems. Therefore,

they did not have the expertise and were not in a position to have an overall understanding of why systems under-performed or the complexities involved to resolve malfunctions, contrary to data managers and strategists. In a similar vein, their reports conveying systems problems were met with what they considered a nonchalant reception, adding to negative sentiments.

7.4. Systems Upgrades

All local authorities implemented enhancements to their systems, intended to expedite processes, improve data quality and security. Ideas for upgrades sometimes originated from staff who through their consistent use meant they could see other ways of improving existing arrangements. Accepting the ANT enrolment concept where actors are required to buy into a network, in this case, these particular social workers were successfully enrolled into adopting technology. The following example demonstrates how a social worker re-assembled IT as a newly constructed network, reshaping through being able to acquire knowledge, influence change and share with other members of IT and social care staff. This strategy created stability and translation whilst maintaining fluidity. This type of re-assembling was observed by Kleif and Faulkner in their work with women and IT courses which expanded their roles and networks in relation to many other aspects of life, i.e. helping co-workers, friends and family through their sense of achievement, feeling of empowerment and increased confidence [(312)]:

> *'We like processes, we like systems, and understand them. Em, and we always get sent on em, to meetings where, like [name of IT designer] needs an understanding of our processes and we're forever getting told to go to meetings because we fully understand these and when all these boys come down from [name of development company] we understand their jargon. Everybody asks, oh how did you know that, you know, because we sit and play in [name of local authority IT system] and open up boxes, and find out what's what. (Interview, Site 2, P203, Social Worker, Thursday, 06/10/2016).*

Data managers and strategists expressed confidence when talking about progression in system performance and reporting. The long-held vision of being able to report in real time was a reality for the one system where social care shared access to the NHS hospital

discharge system. This progress negated the need for lengthy and often unproductive meetings over data validation resulting in more streamlined reporting. The following extract illustrates how, from an ANT perspective, client information was displaced by being transformed through negotiation into coded information, then to spreadsheets, tables and figures ultimately mobilised as statistical analysis. Network tracing activity, illustrates the continually shaping and reshaping of networks and helps to better understand human and non-human relationships particularly as steps in the process are preserved:

> *'Em, the latest change in reporting effective from 1st July this year is that em, at the end of the month, all we're going to do is take a report from [name of IT system] and send it off to the Scottish Government. There's going to be no validation at all on it. That means that we have to be validating that information in real time. Yeh, and we've had road shows and discussions with people like [names of service managers] from the discharge team. So, they know these things are now in place and they have to kind of take action to make sure they're reviewing patients as regularly as necessary to keep that information up to date. So that it's reliable, and by the end of the month we can just fire it off. (Interview, Site 1, P111, Data Manager, Wednesday, 27/07/2016).*

Performance enhancements brought challenges as well as successes especially when staff had to navigate newly launched upgrades. One change introduced a new function where, if a social worker did not use his/her keyboard within a specific time-line, any unsaved work was lost. This was problematic for staff initially as they were often interrupted by the telephone and would become distracted for a time. They would then find the work they completed over a lengthy period disappeared if they did not remember to hit the 'save' key. Similar difficulties occurred during other situations as described below:

> *'The system wouldn't allow her to pull information through so that she could then send the emergency referral to Rapid Response team to pass on to Rapid Response carers. The system indicated she had missed specific information,*

but she could not fathom out what was missing. She checked and double checked everything she could think of and tried all permutations but nothing worked. She had minutes left to get the form submitted [before the referral would miss day-shift workers] and said she was so stressed she wanted to throw the monitor out of the window. By this time it was after 5pm and IT technicians were unavailable. She and her colleague fiddled around and eventually succeeded. Neither knew how they corrected the glitch but they did. In subsequent days, they found out that a previous action performed by another worker on the client's case notes inhibited the progression of the referral' (Fieldnote, Site 3, P305, Social Worker, Thursday, 24/08/2017).

One local authority applied a measure that enabled workers to formally complete their record update which then enabled data managers to pull the information through for reporting and analysis. Sometimes instructions were not salient enough for workers to perform correctly or they would become distracted and forget:

'Thing is for us, when it comes to like data quality, is things potentially like getting the assessment fully completed. So, making sure that aw the bits are filled in and aw the boxes are filled in, an actually the fact you've completed it and finished it, and you've said it's finished. So, in [name of case record management system] when you're saying that you've finished your assessment, you've got a button that's called the 'finish and save' button. And if ye dinna click that, then it doesn't lock it down. What they'll dae is they'll come back to it and they'll think, I've done that right, I'm finished wi them, now that's fine, and then they've no clicked that ***magic button*** *(emphasis in the original).' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).*

System updates designed to assist staff to upload information more quickly and accurately sometimes had the opposite effect. For example, all local authorities incorporated drop-down menu options but rather than help reduce time and errors, some options confused workers making inaccuracies more likely, affecting data quality:

> *'Em, but some of the [name of client record management system] dropdowns, you know, it's no wonder people get confused with what they should be choosing.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

One local authority introduced an icon on each social worker's recording system showing the number of clients they were currently handling. Numbers included 'pending' which meant these cases were completed and stable, but remained under their case-load in case of further incident or need for further assessment or intervention. Numbers were misrepresentative of actual cases being attended to. These artificially high numbers caused workers to worry until after much protest and through manager influence, they were finally taken out:

> *'[Name of social worker] also mentioned that she used to get stressed when looking at the numbers and how the removal helped with her anxiety levels.' (Fieldnote, Site 2, P203, Social Worker, Thursday, 06/04/2017).*

IT system upgrades improved systems performance, functionality and brought reporting procedures closer to real-time recording. Some initiatives had unintended consequences such as loss of work or where new functions created staff anxiety. Upgrades took time to embed into practice however, a lack of clarity and meaning in system instructions led to some inaccuracies impacting data quality.

7.5. Systems Development

There were many examples of health and social care initiatives around systems development. Some resulted in shared IT interaction. For example, one health board developed an in-house system for hospital discharges which health and social care staff jointly accessed. Initially, health and social care staff had 'view only' access, and information from each domain was uploaded by a designated data manager. Over time, its success was recognised by health and social care staff and then subsequently rolled out to ward level and to the hospital discharge team so that staff could upload information themselves. The success of the system was recognised by the Scottish government and was then applied to other Scottish area health boards. It is important to note however, social care had 'view only' access to health information and vice versa

which although brought benefits when co-ordinating patient pathways, information from other hospital IT systems was inaccessible for example, electronic patient records which were required on a daily basis:

> *'There should still be direct communication between health and social care. [Name of hospital IT system] isn't intended to replace all that. It's only intended to be a tool to facilitate that and give us information back as well. But after using it for a couple of years we rolled it out to ward level. Em, it was then picked up by the Scottish Government who have now rolled it out nationally. So, all of the 14 boards and 32 local authorities, for the most part, are using [name of IT system]. (Interview, Site 1, P111, Data Manager, Wednesday, 27/07/2016).*

Some local authority managers showed enthusiasm when commenting about controlled downtime to carry out maintenance or to deal with rare systems failures (due to external factors such as power station outages) with accounts of their infrastructure being 'robust and resilient' (*Interview, P301, Data Manager, Friday, 19/05/2017*). Further developments by this particular local authority meant they were confident to operate a paperless system. This was possible through using additional funds allocated to health and social care partnerships termed 'The Change Fund' [(313)]. Apart from eliminating the need to retain, stock pile and fund storage facilities for large amounts of paper-based client information, paperless management enabled social workers to access information remotely rather than having to return to the office as was previous the case:

> *'So, we spent the last 2 years, we've taken all our client records that were paper based. So, you'd have folders for each client, it's all gone. We scanned everything in, every single file for our clients and scanned into the system, attached to their file in [name of local authority case management system]. So, you just go into it, oh I wonder what's in their file, click an icon, all their file's there.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

Many references were made to the development of IT systems and how designers needed to create models that told the whole story of care pathways as illustrated below. These

comments were voiced by social care executives rather than data managers/analysts when investigating a new case management system:

> *'You know, if you're building your system now, build in the number of people who got home, who, who were, oh well that's not so easy to measure because its, its, you have an exception reporting format. Well, develop one that's not just an exception reporting format. Develop one that actually shows so, because, if you're trying to get change in place and you're trying to demonstrate change that's worked, you actually have to be able to see the good things that you did not just whether you reduced the bad stuff.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

Joint access and interaction with IT systems brought many benefits to health and social care joint working teams where previously most struggled with validating and tracing origins of information. System accessibility was configured such that health and social care could view each other's data but only respective organisations could edit information. This process legitimised data entries as soon as they occurred thus eliminating previous contentions that were aired during weekly or monthly meetings. Through applying ANT symmetry with no *a-priori* assumptions, the following demonstrates how IT played an active rather than passive role in transforming established practices, subsequently influencing the way humans behaved:

> *'But after using it for a few months, and you see the improvements in the validation meetings. You know, I mentioned that we used to have 3-hour validation meetings, people coming with spreadsheets and arguing about the data. Once it was input to [name of hospital IT system], there was no arguing about it because it was there. And you'd put it in yourself, so you couldn't argue about it. You know, and the information that social work had put on, we could see it from health, they could see our data. So if they wanted, we have inbuilt query facilities in [name of hospital IT system] as well, so as soon as the patient appears, social work can query that and say look, we don't agree with these dates, we haven't seen a referral, and we can go straight back to the ward and iron that sort of thing out right at the start.' (Interview, Site 1, P111, Data Manager, Wednesday, 27/07/2016).*

Most data managers and strategists were optimistic about future data linkage projects and joint health and social care systems interaction, although this was not expressed by staff at the front line:

> *'Em, I suppose with integration, hopefully the data will link between social work and health. That is the hope. However, for those of us that are quite eh, [laughs] you know, you think really, will pigs be flying before that happens [laughing]. We seem to have had a lot of em, wonderful, fancy new IT systems and they've not been linked great to health. Em, I hope it gets easier for people. (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

Some social workers operating at the front line were keen to engage with new technological advances whilst it seemed others were more reluctant:

> *'Other challenges [name of social worker] faced included observing inappropriate use of budgets and services when electronic solutions to enable a person to remain in their home were available. She felt that some social workers were set in their ways leading to underuse of the variety of technologies available. For example, an electronic pills dispenser prompts a client to take their medication. The dispenser makes the correct dosage available at the correct time each day whilst keeping the other medication locked out of sight. An alarm sounds when it is time for the user to take their medication and if the pills are not taken from the dispenser within a pre-set period, an alarm call is transmitted to a control centre. [Name of social worker] was keen to describe other available systems including electronic flood, heat and movement detectors, epilepsy monitors and other personal monitoring systems.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).*

Views and experiences expressed during interviews and observations suggest systems development improved patient pathways which were better expedited and monitored when health and social care staff were inter-connected. Additionally, information submitted on such a linked system was tracked meaning it was easily validated. Funds

used creatively to further develop IT systems provided staff with immediate access to information from remote areas, further improving connectivity. Fears remain however, over future IT systems design where there is a call to move away from exception reporting to that of a whole picture approach. Distinct views expressed between strategists and data managers compared with that of front line staff in terms of future interconnectivity are a cause for concern. Additionally, engagement with technology from front line staff perspectives was varied, with some members unwilling to endorse IT resources during care package design. It seems IT systems brought a wide range of benefits but also many drawbacks.

7.6. Disparate Systems

Much of the health literature in UK and in many other countries point to too many disparate IT systems working in silos or which require work-arounds to account for a lack of interoperability, and these experiences were also reported in social care [314-319]. For instance, each local authority operated a stand-alone client record and management systems which was inaccessible by other district authority systems. Consequently, clients who moved across local authority boundaries could not have their notes or service transferred electronically.

Within local authorities, other technologies were employed for example, electronic homecare roster monitoring systems which provided real-time activity of care provider movements. This system operated independently from the primary record management systems. Information including the name of the care provider and hours of planned care were manually uploaded to client records and the homecare roster system, resulting in duplication of work. Additionally, when care companies or services changed or ceased, each system had to be updated separately adding to workloads in already busy environments which could be averted if systems were linked:

> *'You've got to log in twice, [attempting to get on to the other data base]. We'd have to go into [name of local authority IT system]. That's another database, not [name of separate data base].' (Interview, Site 2, P201, Administrator, Tuesday, 04/10/2016).*

The homecare roster monitoring system facilitated real-time electronic recording each time a care provider entered a client's home to perform a service. However, the facility was available to local authority care workers only, not private care companies in two of the three council districts meaning that the vast majority of client visits were not monitored. Payments to private companies were based on scheduled hours of care rather than actual hours carried out leading to potential overpayments by councils, who, under increasing pressure to make drastic savings had no means to accurately audit services provided:

> *'[Name of service co-ordinator] said there is no process at the moment so when contractors send their invoices to finance, they are accepted unless there are clear discrepancies, i.e. claiming for a client out-with their area. Local authorities are able to track council operated services through [name of electronic roster], but now that the majority of services have been transferred to private care providers there are less than 10% of services being monitored via this system.' (Fieldnote, Site 3, P304, Social Worker, Thursday, 17/08/2017).*

Social care staff, using the only health care system that they had access to discovered difficulties when trying to configure additional hardware to the existing network. Both organisations saw the benefits a shared multifunctional printer would bring and each agreed to share costs. However, after purchasing the printer, no one could network the equipment to enable both organisations to use it. IT specialists were consulted to find a solution however conflicting opinions were expressed by respective IT departments leaving workers without a working printer:

> *'I mean, we were a bit naïve, we thought, oh that's great, you know, that'll save us printing out lots on these little desktop printers that are not really fit for purpose. We'll just get one and we'll all share it. And we were trying to get connected up, cause, social work IT came along and said, no, no, it cannae be done, it's two different systems. The guy from the printer firm, Xerox, or wherever said no, no, it can't be done. NHS IT said, yeah, we should be able to do that. So, it's a bit of tussling in the background. But even something that you think would be really, really simple and basic, it's*

not.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).

Other challenges came to light when staff talked about a lack of electronic transfer of records even when social care had access to health systems. Information retrieved from health had to be manually recorded and transmitted to social care systems. Additionally, there were further difficulties when transferring information from social care departments in acute settings to local social work offices. Physical files were transported by a courier service with the potential to incur delays notwithstanding financial costs to routine practices.

Local authorities and the Scottish government recognised system disparities and interoperability issues and consequently attempted to develop a nation-wide network to connect systems securely across boundaries. This large-scale project was perceived as too ambitious incorporating top-down agendas rather than local perspectives and sadly failed:

'I represented the local authority in the multi-agency [name of strategy] and we were one of the ones that said, this is just too friggin complicated. 'Cause what they were trying to do was the whole of Scotland. It wasn't something local, it was national. And the governance to change a field, or a form was a ***nightmare*** *(emphasis in the original). We just couldn't get moving. (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

At the time of observing no formal procedures were in place to secure the delivery or confirm receipt of a hospital referral to social care. IT systems were not configured to consolidate these electronically at the time of observing. Referrals would arrive by various means providing the potential for documents to become misplaced. There were occasions where ward staff would chase a referral to find out what stage it was in the system only to find out it had not been received. This major shortcoming was recognised by managers who had recently changed procedures to incorporate electronic referral only:

'I asked a nurse if she referred patients to social work and if she did, how she did this. She said she did and would fax, phone or send electronically via [name of hospital IT system], highlighting that they'd just began to send via this means. (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).

It was ironic that when talking with clinical staff on wards, there were numerous mentions of health care continuing to work with disparate systems, so social care were not alone in these instances:

'Another nurse mentioned that silo systems had evolved over time and continued to work in isolation, and ***'loads of them'*** *(emphasis in the original). 'They don't talk to each other.' (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).*

Disparate systems resulted in a host of weaknesses. Manual transferring of documents were necessary due to fragmented systems. Referrals were at risk of being lost, duplicated work was common and isolated systems gave rise to restricted monitoring and auditing capabilities. Additionally, even where inter-connectivity was facilitated, there was an inability to network simple hardware equipment so that respective organisations could use. Government initiatives to address acknowledged disparities were viewed too complicated and did not take consideration of regional and local differences or arrangements.

7.7. Systems Inter-connectivity

Almost all staff referred to the numerous different and fragmented health and social care IT systems which did not support interconnectivity. Many viewed one joint system as the ideal to support true health and social care integration. However, there was a strong awareness that in reality this would be at the expense of losing the richness of existing single systems:

'So, they don't even within health have only one system. There's so much. It's just too big, there's no single system that's designed to do all of that. So, you would be sacrificing a lot of quality for having something. We're just

about to move to [name of IT system] which is the new social work case management system. There's going to be [name of hospital] IT link within community health. There's the system that the GPs use. There're systems that are designed around a care home. There isn't any single system actually does all those functions.' (Interview, Site 1, P103, Social Services Manager, Monday, 08/02/2016).

Previously, local authorities tried to develop interfaces to link health and social care systems however there was always an incompatibility in terms of where each organisation was during the development stage resulting in delays and a subsequent breakdown in objectives:

'You know, you know, you develop one bit to a position and go, right we're ready, we could do something. And the other system is going, oh I'm not ready yet. And by the time that system gets up here (indicating in line with them), this system has gone sideways and done something differently. So, you have this problem.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).

Where interfaces were incorporated successfully these were developed from a non-hierarchical bottom-up design involving local knowledge and intuition. Flexibility was a key feature to take account of potential change in systems requirements:

'I think the reason it's good is 'cause it was built from the ground up for a specific purpose, and we built into all our information needs. Em, the only information reports you get out of [name of hospital IT system] basically is, it's a flat file with all the data fields in it. We didn't tailor it to meet any one's needs because those needs change over time. We just output the flat file and people then can select exactly what they want from that.' (Interview, Site 1, P111, Data Manager, Wednesday, 27/07/2016).

A portal that pulls information together was viewed as an alternative pragmatic model in order to co-ordinate care teams, evaluate patient pathways and improve joint delivery of care:

> *'So, my response to that is you'll never have one system, but you might think it is in the future, 'cause it'll be a portal. And what that portal will do is, it'll pull from 2 systems and appear on your screen as if it's the one system. And that is the reality of it. That's how it'll work.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

In spite of progress, some managers felt further data sharing protocols and negotiations were required to clarify and synchronise channels of communication and procedures for future data linking and sharing:

> *'Part of it's about, it's about the interface, part of it's about who drives and who owns data, and, and part of it I think is about the fact that you never seem to get that development at the same time.' (Interview, Site 1, P101, Social Services Manager, Friday, 29/01/2016).*

Many views supported the notion that one system would not solve connectivity issues. Instead, a series of portals, which may appear as one system but which pull information together from isolated systems, was a favoured solution. Future linking of such information would require further data sharing protocols that clearly specify operating procedures and communication channels.

7.8. Systems Security

The Scottish Government stipulates various processes which are necessary to maintain data security. Some key safety aspects included the need to keep information confidential whether through storage or during transmission across networks. There are requirements to provide and regularly update usernames/passwords to authenticate access alongside use of an audit trail to safeguard appropriate access via user login scrutiny. Further statutory responsibilities include the provision of different access levels to protect unauthorised entry. Finally, there is an obligation for all local authorities to be diligent and proactive to reduce exposure to hackers through robust design, back-ups and regular security updates.

System securities were in place across all local authorities, inspected annually through internal audit committees and external agencies via the Scottish Government's Audit

Scotland. These safeguards ensured public sector agencies delivered safe, reliable and secure IT systems in a cost-effective manner. Audits included checks to support maintenance arrangements as mentioned by one data manager:

> *'So, ours is pretty robust and tight, and we're always having to be in compliance with the latest statutory requirements, and that's what we do. So that team over in IT corporate, in another building over there [pointing], look after all that. To look after the wiring, the speed, the servers, the infrastructure. And we look after the product front end and that's the two, that's what we do here.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

Additional observations and interviews helped to confirm sufficient physical and reasoned access controls as explained by on local authority service manager:

> *'[Name of local authority IT system] is a 'bread level' of security, so browse, read, edit, add, delete. So, we can be quite specific about what they can and can't see. So, you can restrict certain bits. So, they might not be able to see an adult protection minute. But they could see the care package.' (Interview, Site 1, P103, Social Services Manager, Monday, 08/02/2016).*

Security inspectors report whether local authorities adhere to data entry controls. For example, to safeguard against duplicate client records, to evidence corporate guidance relating to IT systems and system data, to provide guidance for users in matters such as data protection and local authority code of conduct. Some local authorities were more directed than others in the delivery of these safeguards. For instance, the impending arrival of a new case management system may have resulted in patchy adherence of data entry training in one local authority. The two remaining local authorities had detailed programmes in place:

> *'Yes, students and newly qualified workers em, we've just recently moved from [name of local authority IT system] to a system called [name of another IT system]. So, both of those eh, whether they're students or newly qualified workers em, one of their early pieces of learning that they'll do in terms of*

programme of learning will be em the training and the client information system. (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).

Whilst these statutory responsibilities were in place, some staff commented on issues which hindered functionality and smooth operation:

'If you're in social care premises, sometimes your firewall settings and that don't allow access to health websites. That's another joint working thing that we need to work a lot more closely on.' (Interview, Site 1, P111, Data Manager, Wednesday, 27/07/2016).

Others mentioned difficulties with logins where there was a trade-off between security and accessibility which became problematic causing some workers to avoid using systems:

'I gave them access, but because the two systems, operating systems are different, they just log themselves out because they have to go in as if they're remotely accessing it. So, I gave the 2 CPN managers access and I think it took them 10 minutes to log themselves out. And it just became too hard to constantly reset it. So, you need a way that allows you access it without it being such a complicated level of security to get in.' (Interview, Site 1, P103, Social Services Manager, Monday, 08/02/2016).

Secure IT systems are vital to protect unauthorised or unlawful access to or processing of client data. Safeguards are essential to maintain the integrity and confidentiality of such information. All three local authorities in this study complied with government directives in order to achieve this. Access to information was sometimes problematic due to the high level of security installed which blocked some workers when attempting to access systems. Data controllers were mindful of the need to manage a balance between the two opposing requirements.

7.9. Systems Reliability

One local authority seemed very satisfied with IT reliability where staff commented on how much they preferred their recently upgraded client record management system. There were however, concerns with getting used to new procedures which took some time to become embedded into practice. Yet, on the whole there were more positive than negative remarks from people operating at this site. Comments from data managers in this local authority were also complimentary portraying their system as being 'gorgeous, lovely, robust and resilient'. *(Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).* The following report is a depiction of the views and experiences of systems reliability in this locality, however as discussed in 6.3.1., a shortage of equipment and limited signal strength in urban as well as rural areas restricted reliability in reality:

> *'I mean the down time is something like a **fraction** of a percent (emphasis in the original). It's what you would expect from any decent system. A social worker will not go out worrying whether they'll be able to access the system. They have a valid assumption that they will get it every time they need it. And that's right, that's what they get. So that's not a problem.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

Another district expressed a small number of complaints about system outages or speed of operating. Rather, there were more issues with the lack of system capability. However, this local authority was in the process of procuring a new client record managing system which seemed to defuse any major issues they may have had. They seemed confident present shortcomings would be resolved on the installation of the new system. The remaining local authority complained bitterly about their key system crashing or functioning very slowly on a regular basis. The following quotes are from the same locality regarding hard copy files. Some opinions suggested that although hard copy files were useful for some queries, they did not resolve all issues. Other staff made more positive references to physical files, both are in the context of system failures:

> *'Yeah, that was a few weeks ago, like it [name of IT system] was off for about a week. I think we tidied up and tidied up and did filing and all the **horrible** jobs (emphasis in the original). And then when people phoned up with an*

enquiry, this is like a bible where you can check everything, and we couldn't.' (Interview, Site 2, P201, Administrator, Tuesday, 04/10/2016).

'And it makes it very difficult, so, and if you've got, considering we're all supposed to be you know paperless, but then when the system doesn't work, we need the paper. We need something to get a phone number from somebody's notes. Yes, so that was just so frustrating. (Interview, Site 2, P202, Administrator, Tuesday, 04/10/2016).

The three local authorities under study reported experiences that differed greatly in relation to systems reliability. It is worth bearing in mind that views were in context and contingent on local arrangements and provision. For example, it is reasonable to assume that had one local authority not been in the process of commissioning a brand new record management system, then opinions may have been expressed differently and become more consistent with the other local authority who protested intensely about their unreliable system.

7.10. Summary

In order to understand how social care data flows within social care and across other agencies, it is important to understand the role of IT systems during these processes. This chapter has provided an account of the different types of IT systems operated by local authorities alongside the successes and challenges they faced in this rapidly changing backdrop. Procedures to facilitate joint working through improved governance and data sharing protocols assisted in data development. A great deal of progress was made over the course of the project through local authorities gaining a better understanding of how health and social care integration can be realised from an IT perspective. Clients, systems users and data managers reaped many benefits as a result. However, some IT systems configurations introduced weaknesses and there is still much to do in order to achieve the goal of full interconnectivity and consistent systems functionality. For instance, at the time of observing and interviewing, social care staff were permitted access to just one health IT system; the hospital discharge register located in acute and community hospital settings. It is important to note however, the system did not link directly to any local authority client record management data-base or any other council IT system.

Additionally, local authorities were not connected to other council district systems, therefore, social care data operated in isolation at each locality. Furthermore, views on IT systems from data managers were in contrast to that of front line staff opinions and experiences, exposing a gap in how each viewed IT. Having reported aspects of social care IT systems, the next chapter examines the third main theme from analysis: Organisational Systems, which as the title may suggest, considers factors that influenced social care data from an organisational perspective.

8. CHAPTER 8. THEME 3 – ORGANISATIONAL SYSTEMS

8.1. Introduction

Having outlined themes and sub-themes that emerged from IT systems, this chapter now presents the third of four main themes; Organisational Systems. The chapter reports topics that came to light in relation to any organisational factor which influenced the collection and management processes of social care data. For example, the organisational structure of a company defines its hierarchy, rules, policies and division of labour [320, 321]. It determines how roles are assigned, coordinated and supervised in order to function and to meet its goals [322]. Organisational structures also establish how information flows across departments and management levels and also allows managers to evaluate their effectiveness [320].

The organisational characteristics of social care services are consistent with the wider literature. For example, local authorities are responsible for providing a wide range of public services (over 700) to support people in their community, including town planning, education, waste management and of course social care [323, 324]. They operate independently from central government, however they are audited internally and externally through organisations set up to monitor their performance in specific areas [325]. For instance, the Care Inspectorate regulates and examines social care services in Scotland to make sure that they meet standards and practice mandates [326]. The Accounts Commission examines how local authorities appropriate funds and publishes annual reports on council performance. Additionally, the Health and Care Professions Council (HCPC) and Scottish Social Service Council (SSSC) are statutory regulators of people who work within the social care sector [327, 328].

In Scotland this translates to over 200,000 social services members who are bound by standards through codes of practice, specific qualifications and training [328]. This study discovered eight organisational sub-themes that emerged during analysis which impacted data processes; premises, terms and conditions of employment, co-location, agile working arrangements, joint working, routine social care policies and procedures in practice, training, supervision and continual professional development. These are divided into sections and described below as follows.

8.2. Premises

During observation periods, a variety of different localities were visited ranging from large city headquarters to integrated town developments and small rural departments. Each varied in size and composition offering a range of amenities to support staff and social care services for adult care in the community:

8.2.1. Example of City Environment

'[Name of Community Care Services head office]. This modern building has a corporate atmosphere - very large open plan office consisting of two PC monitors per individual desk space. Desks are arranged in blocks of 2, 4 or 5 amounting to approximately 100 in a 'hot desking' structure. This is a very busy office with lots of hustle and bustle, but not noisy. Premises are well catered for in terms of canteen and restroom facilities including showers and changing rooms – all are spotlessly clean, light and airy. On entry, everyone smiled and seemed jovial, giving the office a warm and friendly feel. Although the council operate a hot desking structure, [name of social worker] told me most seemed to sit at the same desk each day, making their space more individual with their own artefacts.' (Fieldnote, Site 1, P102, Social Worker, Tuesday, 02/02/2016).

8.2.2. Example of Town Environment

[Name of locality office] is a new state of the art, purpose-built building which has been specifically designed to accommodate people who require assisted living or who have dementia. The site consists of approximately thirty, 1 and 2 bedroom supported housing bungalows provided by 24hr care. The site also has a dementia unit, respite section and a day care centre. The complex interconnects to the main 2 story building through a double height atrium, a light glazed communal area with facilities such as activity rooms, a large entertainment area and kitchen to accommodate community functions. Within the centre sits the [name of locality] social work department on the upper floor in bright spacious offices. [Name of locality] operates a hot desking policy but this department do not adhere. Employees have their own office space. The department is well served with facilities

such as kitchen/dining room and modern shower/toilet amenities. Offices accommodate care managers, care assessors, local authority care support staff, community alarm staff and OTs. The admin office sits in a communal area accessible from all offices. There are a few other single offices to accommodate the head of the department, admin manager as well as a meeting room with a large oval boardroom table in the centre of the room. The meeting room looks as though it could accommodate over a dozen people comfortably. Office desks are displayed in a manner to suit workers preferences. Each space is personalised displaying artefacts such as photographs, plants, knickknacks and memorabilia, giving the offices a warm feel. I was introduced to many of the staff present. They seemed a happy bunch and gave me a warm welcome. Even before I sat down, [name of administrator] asked me if I would like a cup of tea – which I accepted gratefully. (Fieldnote, Site 2, P203, Social Worker, Tuesday, 04/10/2016).

8.2.3. Example of Semi-rural Environment

'I arrived at [name of department], in the main market square, in the middle of the high street and found it was used as a cattle market during the 17th to 19th centuries. The social work department building, was built in 1874 with a late 20th century extension to the rear.

The third floor leading to [name of social worker] office was very uneven and I tripped walking along the corridor. The ribbed industrial carpet was rippled and heavily duct-taped in places adding to the bumpiness. Harsh fluorescent lighting lit the dark narrow corridor which was lined with around half a dozen large water containers next to a water dispenser, small fridge and microwave oven. [Name of social worker] later explained that because they had no source of water other than a toilet sink on her floor, the council had to provide drinking water. We entered her office which looked fairly large with high corniced ceilings. The three large stone mullioned windows in the office offered a birds-eye view of the market square. Another once-impressive looking building stood directly opposite the square however, it was in a derelict state with many of its window's boarded up and

bushes were growing out of the masonry walls and guttering. [Name of 2 co-workers] and I admired the wonderful light entering the room and also at the view across the square. I'm afraid that is where the compliments stopped as on further observation, I began to notice the poor condition of their office. The ceiling cornice above [name of social worker] desk had become detached from the main ceiling trusses exposing a very long and wide crack. [Name of social worker] showed me how she used a bucket to catch leaking water during rainy periods to stop her computer and paperwork from being splashed. The carpet in her room was heavily stained, rippled and taped in numerous places to conceal tears. It was very much in need of replacement. Old electrical cabling suffering from countless layers of paint over the years were visible on all walls. Office furniture was an old and odd mix in design, structure and composition giving the room a shabby and tired look.

The building was the first I had visited where the two extremes of appreciation came to light - magnificent and dire in equal measures. There were 4 desks in [name of social worker] office; 2 on one side of the room in a face to face configuration and another 2, positioned perpendicular to each other on the other side. [Name of social worker] mentioned that her desk was designated to her since she was permanently based in [name of town]. Her desk space was consequently personalised with photographs and other artefacts. The other 3 desks were designated agile working stations. There was a waist height cabinet at the far end of the room which housed a kettle, toaster, cups and crockery as a makeshift tea/snack making area. [Name of social worker] showed me a basin in a filing cabinet at the opposite end of the room which she used to store dirty dishes which she would clean at the end of the day. The nearest washing facilities were 3 floors below. Later in the day after talking to her colleagues it transpired that washing facilities on the ground floor were a 'health hazard' making workers reluctant to use. There was no evidence of ergonomic keyboards in sight but I did spot one footstool in the department. [Name of social worker] told me there was talk of the department moving to [name of 2 other sites], but nothing was definite.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).

Some building configurations made customary gatherings in restrooms for lunch or break times awkward even in localities where good break-out facilities were provided. Some workers had no facilities what so ever, whilst others had limited nooks in corners of offices. Even where ample provision was evident, the layout of rooms made break times challenging at some locations:

> *'She also mentioned that they sometimes got told off for laughing too much, further explaining that the way the building was arranged didn't help. For instance, the canteen was situated immediately next door to the board room. There were some occasions where meetings were being held but the noise and hilarity from the canteen was sometimes interfering with tasks in the boardroom!' (Fieldnote, Site 1, P107, Social Worker, Tuesday, 15/03/2016).*

The extent to which local authorities provided adequate working conditions for their staff was an important factor for participants throughout the study period. Almost all made reference to their work place amenities and state of office repair. Staff were keen to point out well maintained office spaces and pleasant surroundings. Never-the-less, references were also made to facilities that were lacking or derisory. Staff experiences were diverse; some environments were better than others as noted above. There was a clear difference in atmosphere where departments were well catered for as opposed to those poorly served. More negative comments emerged from staff working in less desirable conditions than those who were well provided for. In these instances, disapproving comments were not just confined to premises, but encompassed around inefficient work practices, a lack of leadership, and service provision restrictions, as if to reflect negative associations of their surroundings. For example, two small locality offices were organised so that in theory, they worked as one team. However, respective manager views led to disagreements around team organisation. Therefore, appeals to incorporate a duty worker rota or arrange joint team meetings were not realised. Both localities operated in isolation denying staff opportunities to collaborate.

8.3. Terms and Conditions of Employment

Throughout interviews and observations references were made to terms and conditions of employment between NHS and social care staff. Contracts seemed to be a great source of angst amongst social care staff particularly when working in joint teams alongside healthcare staff. Many felt undervalued and subservient when working alongside health and social care partnerships due to health care staff having more generous employment conditions than social care, despite performing identical tasks:

> *'When the role was advertised for [name of manager] role. If you were a health person, you got a better salary than if you were a local authority person and got the job.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).*

Career progression for social work employees was hampered through the unequal criteria between health and social staff care when attempting to fit into new integrated positions. Advancement was more advantageous to health workers presenting further discrimination against social care staff. And although the situation originated by default, there was no inclination from either organisation to address the disparity:

> *'I think it's because they're under different sets of legislation. I suppose when you get to something, the way to approach it is that if you're a health member of staff, it's under your terms and conditions. So, matching into post, for example, the new structure comes out. They're looking at how many people match into a post. The health HR policy is you'd do 50% of that job you're matched into. The social work one is 80%. If a health member of staff's doing 50% of that job, they could match into it. So, if I'm doing 50% of a job and they're doing 50% of a job, they're a match and I'm not [because of the 80% threshold]. Because I'm under social work with the council.' (Interview, Site 1, P103, Social Services Manager, Monday 08/02/2016).*

Others made reference to health administrators having a remit that was viewed as being less complex than social work administrative roles when working alongside one another. Social care staff considered tasks and staff grading were out of alignment,

notwithstanding higher NHS salaries and more generous annual leave compared to their social care counterparts, meaning some felt under-rated:

> *'I mean we, we see, you know, and the girls that we work with are really nice and we get on great and we do work together, em, but obviously I could be doing a whole load of other stuff, work, em, like the processes, the new computer system, you know, em and then you're perhaps sitting next to a colleague who's sitting **typing** all day, who's getting **paid** more (emphasis in the original).' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

Other comments were made around a lack of motivation to align health and social care staff in grading and level. For example, some administrators and managers are employed by NHS and others by local authorities performing identical tasks. Under health and social care integration, they work alongside each other however there is no common approach to terms and conditions, leading to a sense of unfairness breeding an underlying wave of resentment:

> *'I think a lot of this is in the 'too hard' box. So like terms and conditions are different, and I don't think anybody's got a particular appetite to address that.' (Interview, Site 1, P103, Social Services Manager, Monday 08/02/2016).*

As part of an NHS employment contract there is a non-redundancy policy in contrast to social care contracts. Staff commented that if partnership savings were required there was a fear there may be a tendency to release social care employees rather than NHS personnel. All staff seemed very aware of inequity which bred uncertainty over job security and a sense of dilution of their profession:

> *'It comes up every second sentence. Well, it doesn't but we're very aware of that. So, when we joined up health and social care, how come they've got job security and we don't? Why have they got a job for life and a non-redundancy policy and we don't? So, does that mean that when the health*

and social care partnership has savings to make, it's easier to make them on the social care side? 'Cause they can let us go but they can't let go of a health person. So, so we're very aware of that.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).

Temporary contracts were another source of worry where HR were often slow to inform staff of continuing work. Consequently, staff members felt insecure working on these conditions, reiterating how mortgage companies were reluctant to accept salary totals unless they were under a permanent contract:

'[Name of social worker] told me that she had been given a temporary contract 3½ years ago and is still waiting to find out if it will become a permanent position. She recalled the day before her contract was up where she had to ask HR if she was to come in to work the following morning as she had not been informed if her contract was being renewed.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).

There was also a sense of social work being thought of as the poor relation to health. Staff at one local authority complained intensely about budget constraints which increased tension around service provision:

'[Name of social worker] and I talked further and she told me about the pressure and sense of unfairness that cut-backs brought. For example, social work community support workers, that is people who carry out tasks like shopping etc for clients were all cut from her department leaving no provision for this important service. However, health still held all their community support workers.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).

Different terms and conditions of employment had the potential to impact routine function and management of joint working teams. For example, NHS line managers in charge of local authority social care staff cannot access their personal information under existing regulations. Managers are therefore unable to monitor instances such as short

or long-term absences preventing them from taking steps, such as finding a temporary replacement without prior authority from an individual. This type of scenario did not occur whilst observing, although it is a serious consideration when moving closer to absolute health and social care integration:

> *'So, your sickness record for instance, may not be disclosed to that manager. So how does that manager **manage** you if they cannae deal with your sickness (emphasis in the original)? So, I think from a terms and conditions perspective, it is still that, well how di ye expect us to **work** together (emphasis in the original)? (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).*

Most staff were aware of incongruities between organisations and some were more accepting of the differences than others:

> *'And to be fair, that's on the table and everybody's totally aware that there are these discrepancies and it does affect how teams behave and join and it's a problem that we've still to resolve for the future. So, it's not like its hidden. It's out there and everybody knows it. Doesn't actually, to be honest, doesn't influence how we relate to our partners here in health at all. (Interview, P301, Data Manager, Friday, 19/05/2017).*

> *'I've certainly had that experience in my previous post where there were tensions around terms and conditions and that can be really undermining and divisive' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

Terms and conditions of employment featured highly over the course of the study. Inequalities in role alignment, salary, redundancy policies and career development induced job uncertainty and professional inferiority from a social care perspective. Despite these biases, social care staff worked within the parameters afforded, although if authorities do not address such matters, continued injustices have the potential to jeopardise joint working initiatives as health and social care integrate further.

8.4. Co-location

Despite terms and conditions causing tension and resentment amongst some social care staff, working with other professions also brought a wealth of knowledge and a greater understanding of respective professions' priorities, policies and challenges. Formal and informal network building was facilitated and previous limited knowledge of each other's roles and responsibilities was enhanced, assisting enormously in joint ventures:

> *'[Name of social worker] and I talked more and she mentioned she felt that having a mixture of professional roles and backgrounds working from the same location helped tremendously in the transfer/sharing/deciphering of information [OTs, nurses, social workers, AHPs]. For instance, social workers are not always familiar with medical terminology used on referral forms. She explained that the symbol # can also mean a fracture. Having a mixture of professions on-site helped with these issues. Proximity also helped forge inter-professional relationships and gain a better understanding of other professional roles. Likewise, other professions were able to gain more insight from a social work perspective.' (Fieldnote, Site 2, P203, Social Worker, Thursday, 6/10/2016).*

Other workers talked about how they established inter-professional relationships through co-location; helping to support strong collaboration resulting in better client outcomes and joint working in less formal situations:

> *'[Name of social worker] mentioned that co-locating with other departments were a big advantage. She would often pop down to housing [on the floor below] to inform of client applications, even when there was no need. She felt it was important to build relationships and share information with everyone involved with her clients.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).*

Co-locating was beneficial not just for offering the potential to build inter-professional relationships through formal and informal interactions. Colleagues working alongside each other were able to support one another with client issues. Co-location was also viewed as vital to successful health and social care integration however, there was an

awareness of the need to maintain a balance of co-location as voiced by one service manager:

> *'It's been really good from the point of view of we're co-located up here and that's been a massive benefit. I think you don't get people shunting you, so you've got a team up here that if there's a problem then everybody can try and resolve that together. In terms of how we get from where we are now to where we want to be, [pause], I don't think we're, [pause]. So, finding places where you can co-locate staff trying to get some alignment between people we work with so the particular thing in [name of locality] is around the GP practices that are in one area. So, if you move towards a locality way of working you slightly disconnect yourself from that, and if you move towards working more closely with the GPs you disconnect from localities. But we're finding ways of working through that. So, I suppose we're, we've just moved towards community social work teams, it's just finding ways that we can build on the working relationships with other professionals. (Interview, Site 1, P103, Social Services Manager, Monday 08/02/2016).*

Co-location was viewed extremely positively in view of health and social care integration. Staff from both organisations developed a mutually appreciated understanding of each other's roles and responsibilities. Professional relationships were able to flourish through working in close proximity where reciprocal support helped with case work concerns in a timely manner, resulting in more favourable client outcomes.

8.5. Agile Working Arrangements

Agile working or hot desking and mobile working as it is also known is characterised under the umbrella term of 'flexible working', an employment approach endorsed by the UK and Scottish governments [329-331]. Amongst other features, workers are able to operate from different locations. For example, from home, office break-out areas, cafés, libraries and other mobile settings. This style of operating has many benefits for employers and employees alike. Employers save in office space and running costs, facilitate extended business hours and increase business continuity (i.e. less disruption during inclement weather) [331]. Employees on the other hand are able to reduce travelling

time and associated costs, afforded flexibility and freedom to choose where to work to maximise time, resources and improve work-life balance [330, 332].

All local authorities under study operated an agile working policy for all social workers. With this approach comes the removal of desk ownership but whilst observing I noticed workers would sit at the same desk space each day despite policy ruling. This practice was linked to people also wishing to sit next to or near the same people day-to-day. Desks were personalised with photographs, trinkets and other personal items:

> *'The council operate a hot desking policy, however [name of social worker] told me most seemed to sit at the same desk each day, making their space more individual with their own artefacts.' (Fieldnote, Site 1, P102, Social Worker, Tuesday, 02/02/2016).*

I received many comments relating to this practice. Some departments were just about to make the switch where many were unconvinced of agile working in reality:

> *'Both emphasised they had no way of accessing their system remotely although understand that some form of provision will be made. However, they have not been told how or through which means. They are concerned about the reliability of their electronic system. At the moment, if their system goes down, they have every client record in paper form to hand in the admin office. Therefore, if they are working in the field or from home and the system crashes, they feel numerous and unnecessary journeys to the office would have to be made undermining the principles of the policy in their opinion.' (Fieldnote, Site 2, P208, Social Worker, Thursday, 22/06/2017).*

Many others made their feelings clear on how agile working affected their work practice. Some were in favour whilst others less so:

> *'[Name of social worker] explained her understanding of agile working which was to enable flexible working locations, i.e., from home or out in the field [and to save the council funds by providing fewer desk spaces etc]. She*

said she was the type of person who liked to draw a firm line between work and home life. Therefore, hot desking did not appeal to her. [Name of social worker] also mentioned that if she chose to work from home, she could not access her system, therefore her work was limited in scope. [Name of another social worker in the same office] liked the idea of being able to work from home from time to time, but agreed only limited tasks could be completed without access to her system. Also, she mentioned that she spent an awful lot of time calling people on the telephone and since no work mobile phones are provided at the moment, she would have to meet those costs herself when working from home.' (Fieldnote, Site 2, P206, Social Worker, Tuesday, 20/06/2017).

Agile working meant local authorities were at liberty to reduce office and desk space which caused problems when staff arrived at the office on busy days. Insufficient room meant some workers had to go home or find a place in corridors or rest areas reversing the rationale behind the policy:

'I went over to [name of social worker] and we talked a bit, but there was nowhere to sit. She hunted around, eventually found a chair and so I sat perched at the end of her desk. I felt quite conspicuous as my chair blocked the passage that enabled 3 workers to move around the office. The place seemed really crowded with every desk taken up.' (Fieldnote, Site 3, P304, Social Worker, Friday 18/08/2017).

Most workers preferred to have their own desk space and created workarounds to ensure they worked from the same space each day. In offices where desks were in short supply, workers would ensure they arrived in the office early each morning to reserve their place. Other departments created an implicit form of order where everyone knew where everyone else sat each day. One service manager was a supporter of personal workplaces and did not enforce agile working as the following quote illustrates:

'I also spoke to [name of service manager] about 'hot desking' [agile or mobile working as it is also known] as this was a big topic for discussion in other areas. She did not seem to be a fan of hot desking and confirmed her

workers sit where they chose and personalised their space. She feels an awful lot of informal learning takes place when colleagues sit together through choice and routine. Also, there was an element of reflective practice conducted in these settings. Workers would share experiences and draw from other colleagues in helping them to be more reflexive practitioners.' (Fieldnote, Site 2, P209, Social Services Manager, Tuesday, 20/06/2017).

NHS and social care staff differed not only in employment terms and conditions, but also in values, practice and culture which are discussed further in the next chapter. An additional distinction was made in terms of the NHS who do not operate an agile working policy. Therefore, health colleagues working alongside social care staff were provided dedicated desk spaces funded by the NHS. This became a bone of contention in some localities as social care workers viewed this prerogative as a further example of the divide between organisations making social workers feeling belittled by comparison:

'Because NHS doesn't have an agile working policy or a hot desking policy. So, the head of service (NHS) paid for desk space in this building so therefore health staff are ***entitled*** *to a desk space (emphasis in the original).' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).*

An agile working policy was incorporated at the three local authorities under study for all social workers. The policy was enacted differently by different localities, depending on the structure of the building, provision of desk space and team management style. The strategy earned mixed reviews with some more supportive than others. The provision of dedicated NHS desk space during integrated working is an area of concern for some workers impacting their professional worth.

8.6. Joint Working

Successful joint working ventures between health and social care had a positive impact on client outcomes and care pathways. Many references were made to initiatives such as prevention strategies, namely Step-up-Care, Rapid Response teams, Early Intervention teams and Respite to avoid unplanned admissions to acute hospitals. Similarly, Immediate Discharge Service (also called Early Supported Discharge) was another initiative, introduced to reduce hospital delayed discharges. MDT meetings in hospital

wards and community practices served to share up to the minute information which helped expedite care pathways to meet client need. All social care staff involved welcomed improved communication and co-ordination MDTs brought but some wished this collaboration could extend to other adaptable ways of working to further improve care:

> *'[Name of social worker] confirmed MDTs were working very well but wished other things could be as flexible with integration. For instance, there are times, where a district nurse is needed at 7.30am. And due to the rigidity of their schedule, they are unable to provide services at that time of the morning, whereas social workers tend to be more flexible with their appointments. One of [name of social worker] clients was receiving palliative care. He required a nurse to attend to his medical needs at 7.30am. The immediate response to her request was 'that's not going to happen, I don't start till 8am'. [Name of social worker] and other social workers said they often arranged appointments with families after 5pm as it was the only time some family members could attend due to work. Similarly, they often arrived at work around 7am so that they could complete administration tasks without being interrupted by the telephone.' (Fieldnote, Site 2, P206, Social Worker, Thursday 13/04/2017).*

Not all social work localities adopted MDT meetings as arrangements were left to the discretion of team managers. Where these meetings were absent, relationships between health and social care were more distant preventing the experiential learning in formal and informal settings. Sharing information and gaining a greater understanding of different roles and responsibilities were also limited. Joint teams who held regular MDT meetings were driven primarily through strong team leadership which through effort provided the appropriate organisational environment to help achieve collaborative practices, more holistic care co-ordination and positive client outcomes.

Despite some excellent examples of joint working, some commented on a lack of alignment and clarity in organisational structure and guidelines which led to confusion over how to communicate/resolve failures during crisis periods, and who was responsible for doing this. Refusal to accept responsibility caused difficulties when

attempting to disentangle problems during breakdown in systems with a seemingly 'pass the buck' attitude. Organisational factors can be instrumental in the creation or maintenance of professional boundaries [333]. Professions can either take ownership of problems to reinforce professional standing, or through distancing their profession to uphold divisions by absolving their field from the responsibility of the task [272]. The following excerpt illustrates the latter where different organisations were reluctant to take ownership of problems and who also expressed an unwillingness to collaborate in an attempt to resolve matters. Waring observed these strategies and tactics being enacted in hospital discharge settings between health and social care staff which maintained professional boundaries through a culture of blame [333]:

> *'You've got 3 different sources, 3 different people with different interests saying different things. I find that with [name of hospital IT system) itself. Because the data base belongs to [pause] well each board posts its own data base, so for these purposes, [name of health board] owns our [name of hospital] database. It's hosted by [name of third party], a private company really, on behalf of the Scottish Government. So, we have problems with overlap there. If we have a problem with [name of IT platform], you go to [name of third party] and complain to them about it. And they say oh, that particular aspect of it is [name of subsidiary IT company] responsibility. So, you contact [name of subsidiary IT company] and they say, ah yeh, but we can't do anything because this set-up thing by [name of third party] prevents us doing that. And I'm in the middle saying, well I don't care whose fault it is, we just want it resolved. And there's a reluctance to even try things or to work together, I find personally.' (Interview, Site 1, P111, Data Manager, Wednesday, 27/07/2016).*

Local authorities were responsible for developing respective policies however, there was a lack of joint strategy when patients attended their area health board hospitals. For instance, some health boards handled patients from a range of councils, each differed in policy in terms of payment for equipment such as adjustable beds, pressure care mattresses, walking frames and other mobility aids. Hospital staff were left with the burden of charging some patients whilst others, perhaps located in the next bed received

equipment free of charge. Of the three councils studied, two local authorities did not levy charges whilst the remaining council did:

> *'When talking about patients from different local authority districts, one OT told me that she found it unfair that patients from [names of 3 local authority districts] who did not have to pay for equipment. However, patients from [name of another local authority district] were billed. She felt that some patients might not receive the necessary equipment due to an inability to pay. She told me about getting letters from [name of district council] saying that they could not retrieve monies from some patients because written consent agreeing to pay was not received in documents.' (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).*

Social care experiences of joint working were acknowledged with broad support where many initiatives worked well in acute and community settings, benefiting client care pathways and outcomes. However, not all localities participated in community MDT meetings as some managers were indifferent to the strategy. Some joint working problem solving was therefore hindered, with an unwillingness to collaborate from some sectors. A lack of clear organisational procedures was believed to exacerbate these issues. Social care staff who engaged in MDTs were eager to extend joint working hours to accommodate more flexibility from district nurses, but at the time of writing, no proposals were in place. Local authorities developed respective policies and procedures in isolation offering different levels of facilities, creating inequalities particularly in acute settings.

8.7. Every Day Social Care Policies and Procedures in Practice

Health and social care staff were guided by respective local authority policies and procedures to effect care provision. For example, an integral feature of a social worker's duties was to co-ordinate the implementation of care packages which often resulted in smooth and speedy care provision through different agencies:

> *'[Name of social worker] next task was to deal with a carer's request for respite. She had already carried out the assessment on a previous visit and felt that respite was not needed but that [name of client] would benefit from*

day care in order that [name of wife of client] could have a rest from her husband. [Name of client] suffered from epilepsy, memory problems and was in the process of being tested for dementia. [Name of social worker] completed a [name of form] on her system which then confirmed [name of client] on the waiting list with a local charity. At the assessment visit, [name of social worker] also recommended a seizure alert as [name of client] would sometimes have a seizure during the night. [Name of wife of client] slept in a different bedroom and could not hear her husband. She would worry and become anxious during the night which affected the quality of her sleep. This type of alarm is fitted to the mattress which activates when someone suffers an attack. [Name of social worker] sprang into action and processed the consent form that a client endorses to acknowledge they are requesting a community alarm. A form was then generated which specified the type of community alarm, and in this case it was a seizure alert. The signed consent alongside the request were faxed to [name of headquarters for community alarms) for action. [Name of social worker] popped next door to the local community alarm workers as a courtesy to let them know the request had been placed. [Name of social worker] said that alarms can often be installed within 24hrs and that's exactly what happened in this case. [Name of social worker] also felt that a fire safety check was appropriate due to the client's memory problems. The next task was to request a home fire safety check through the head office at the Scottish Fire and Rescue Service. [Name of social worker] completed the standardised form for this request which she then sent in electronic form. A duty fire check was subsequently arranged between the fire and rescue service and client which was recorded on the case management system.' (Fieldnote, Site 2, P206, Social Worker, Tuesday 20/06/2017).

Each district authority followed respective care policies, and although all were in line with government directives, how these mandates were carried out on the ground differed. For example, during the hospital discharge process, some local authorities permitted ward staff to contact care providers directly to re-commence services without prior approval from social services, whilst other local authorities insisted on being contacted in the first instance. This understandably led to oversights by nursing staff who confused

different local authority procedures resulting in patients being released from a ward without any care cover or without social work knowledge of the discharge. Ward staff, having contacted care providers, would often forget to inform social work. On the other hand, care providers assumed social work held knowledge of the event. Experienced care providers (who had previous experience of slip-ups over the years and who had already forged good relationships with social work departments), took it upon themselves to contact social work as a precautionary measure.

> *'[Name of service co-ordinator] of 28 years gave me a few examples. Last week she received a phone call from a private care provider saying 'Do you know Mrs X has been discharged?' But of course, social work had not been informed. It transpired that ward staff at [name of hospital] contacted the care company directly to recommence a service rather than getting in touch with social work.' (Fieldnote, Site 3, P304, Social Worker, Thursday 17/08/2017).*

Social care policies, did not always result in day-to-day smooth running of services. A lack of flexibility and co-ordination was mentioned during MDT meetings where staff expressed concerns over an inability to provide timely care for some clients when they did not fit the standard geographical criteria. In many cases this involved clients who were registered with a GP just one or two miles outside the designated health and social care partnership locality:

> *'District Nurses also mentioned issues with cross border patients. This is where patients/clients may live in say for instance, [name of local authority district] but have a GP in [name of different local authority district]. This caused all sorts of problems, from allocating resources to delays in finding out pertinent information. (Fieldnote, Site 2, P206, Social Worker, Thursday, 06 04 2017).*

During interviews and observations care provision was mentioned numerous times, primarily in relation to comparisons between private care providers and local authority employees. Many were troubled over the decision by all three local authorities studied to outsource care-at-home in order to meet budget constraints. One local authority had

recently increased the proportion of its homecare services from 50% to 90% to private care providers. Almost all staff worried over care quality and future provision and the impact on client health and care need:

> *'During the meeting, nurses discussed issues with care providers and expressed discontent with the system of new homecare providers. They complained that private care companies had a much higher turnover than local authority employees meaning that there was less consistency with service user care. Issues with training were also mentioned where catheter knowledge was almost non-existent and that district nurses would be called out with problems that could have been easily overcome had adequate training been provided. They felt that feedback/communication was also very poor.' (Fieldnote, Site 2, P206, Social Worker, Thursday, 06 04 2017).*

These comments seemed consistent with what was observed on more than one occasion. Serious situations occurred involving clients whose health had deteriorated during carer visits however, the care provider did not feed the decline back to line managers as per their contract and moral duty of care. Crises resulted and clients were subsequently admitted to acute settings or emergency respite. The following is an excerpt from an incident where a GP called the local authority requesting emergency respite for one of her patients, but the news of the decline in functional ability was new to social care despite carers being in attendance four times per day. The following example illustrates a lack of feedback from care providers and also the different boundaries of knowledge between the local authority and private care provider:

> *'[Name of social worker] became more concerned as to why the carers did not report this. She called the carers a few times more to find out what feedback they could provide, but was unable to get in touch directly. She presumed carers were on other client visits and unable to get in touch. She then called the care company but they could not offer any news. At the end of the day, and still unable to get in touch with carers, [Name of social worker] called the care company one last time and asked that the carers call*

her office phone a.s.a.p.' (Fieldnote, Site 1, P107, Social Worker, Monday, 28/03/2016).

There were many discussions where staff compared the quality of care provided by local authority carers versus private care providers. There were numerous references praising private care company workers, most of whom were dedicated and hard-working. This was despite many enduring zero hours contracts, minimum wage salary and being paid only for work conducted rather than allowing travelling time or mileage costs between clients. Working conditions almost always meant split shifts, weekends and unsociable hours at no additional pay; also confirmed by the Kings Fund in their recent report [334]. There were however, reports of shortcomings in quality and consistency. Managers remarked at how much less training was provided in the private sector compared to those employed by the local authority. Private contractors could access council training courses if wished i.e. catheter care, movement and handling workshops however, not all companies enrolled. It was unsurprising to hear high turnover in staff numbers. Others were complimentary when commenting on private care companies referring to more flexibility around some aspects of care compared to local authority employees. The flexibility in tasks that were performed placed a clear element of risk to patient wellbeing, particularly from a medication prompting perspective:

'I asked if [name of service co-ordinator] found differences between the two types of organisations. She said there were lots of differences. On one hand, private contractors were more amenable to administering medication where perhaps more than prompting was required. For instance, council workers are only permitted to prompt medication that is enclosed in blister packs [no bottles]. They are not allowed to administer any cream or eye drops that are steroid based, or to heat shoulder packs in a microwave oven. Private contractors on the other hand prompt all medication listed in the MAR sheet (Medication Administration Record) irrespective of whether medications were in blister packs or not. Private contractors can also perform the other prohibited local authority tasks mentioned. (Fieldnote, Site 3, P304, Social Worker, Thursday, 17/08/2017).

Communications between private care providers and social care service co-ordinators seemed heavily dependent upon the nature of the relationship that had developed over time between both organisations despite protocols being in place. Some private care companies were very efficient at communicating anomalies as soon as they arose, others were less than adequate. Managers were concerned that with over 90% of care-at-home services now under private contractors, many of whom had only recently began to operate within local authorities, communications and breakdowns in services were inevitable. As one service co-ordinator remarked: 'Relationship building takes time' *(Fieldnote, P304, Social Worker, Thursday, 17/08/2017),* a statement also noted by Holt and colleagues [296]. This account is also consistent with Strauss's negotiated order where mutual understandings in everyday practices require original periods of coaching which even when established are temporal, malleable, contingent and subject to further negotiation [262].

There were examples of private care companies who did not meet their contractual obligations which in some cases were only brought to light during review meetings. A review is normally conducted with a client six weeks following the beginning of a service and then every year thereafter. If information was not shared about service quality at the review, clients could be subject to poor quality care for an extended period of time. Workers mentioned clients often did not like to complain about services and it was normally family members who would reveal substandard care. The following example occurred when I accompanied a social worker to visit a gentleman who was a double amputee. His family were in attendance at the review meeting:

> *'The son said that they [carers] were ok but instead of receiving 2 x carers 4 times per day, often just 1 carer would arrive. This meant his dad struggled to transfer from the bed into the hoist or the bed into his wheelchair. He said his head and neck hurt every time he was manoeuvred. [Name of social worker] was very unhappy that the care company was not fulfilling the agreed plan.' (Fieldnote, Site 3, P306, Social Worker, Wednesday, 23/08/2017).*

Long serving and senior social workers felt strained and talked about a lack of resources to meet increasing demands causing dismay and frustration. Staff mentioned they were

at a point where their thought process was around the most realistic service they could provide rather than what was the best for the client, compromising their principles of client-centered and holistic care:

> *'I spoke to another team lead this morning and she was just running around, she'd staff off sick, em she's not been able to delegate stuff because she doesn't have the right people who are actually present at work to help her. They're trying to protect teams but they're also trying to respond to the demands that are coming down on them from the other managers.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

At a time when local authorities are under extreme financial constraints, some social workers felt it was prudent to make savings that do not adversely impact upon frontline services wherever possible. Currently, in two of the three local authorities, private care-at-home providers submit their invoices to local authority finance departments where payments are made on scheduled hours with no method to check actual hours of care delivered. One local authority changed their system to include electronic monitoring of carer movements and noticed substantial savings when invoices were reconciled against real-time carer visits. The two remaining authorities provided this scheme for local authority employed carers but not privately contracted companies. Given the rapid change from 50% to 90% to privately contracted provision, local authorities appeared to have missed a valuable opportunity to collect these data in order to make efficiency savings and to streamline existing services. Managers were aware of this weakness but one local authority highlighted changes could not be made until electronic monitoring was built into signed contracts when renewal was due:

> *'So, we're going through that now. We're putting in real-time monitoring, it's a requirement in our new contracts with care providers.' (Interview, Site 3, P301, Data Manager, Friday 19/05/2017).*

Some workers pointed out other shortcomings within the Scottish system of care provision where some data not presently collected could assist with financial savings without impacting client care. For example, one particular social worker (who,

incidentally was English) talked about Attendance Allowance, which is a national provision awarded to people, including those over 65 years who may require help to live independently at home due to illness or disability. This allowance is intended to pay for services such as personal care. Applications for this award are submitted through the Department for Work and Pensions (DWP) at their office in Wolverhampton, West Midlands. Social care staff in Scotland do not collect this information:

> *'The award is not means tested and is tax free. Later, [name of social worker] also mentioned that she thought the system was severely flawed in Scotland as people in receipt of Attendance Allowance who then go on to receive a care package are still paid this funding despite the fact that the local authority pay for their personal care.' (Fieldnote, Site 2, P203, Social Worker, Tuesday, 04/10/2016).*

As one might expect, social work team managers varied in work practice and this was reflected in their reporting. Many administrators were able to tell which team made which report just by looking at the structure (or lack thereof) and in reading narratives. Team members were often left to their own devices or followed their leader's example and this is discussed more in the section 'Training' below (8.8.). Some workers took umbrage at having to carry out what they perceived as administrative tasks:

> *'I recently took over line management of them, about a year ago, em, what happened was they (administrators) were previously line managed by team managers who were social workers not adminy type people. So, you had teams that were doing things completely different ways. And when we brought the teams together, we were like, Oh My God, you've got 4 teams doing 4 different things, you know, and em, [name of senior administrator] used to think, she used to say, Oh My God, that teams all wrong, and this is all wrong, and that. So, we've been slowly, painfully trying to get the team managers on board to agree the way they'll do things. To get them to conform to do things properly and then to feed that out to the teams, because a lot of the teams were just left to just get on with things. (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

Other organisational configurations often made tasks difficult where a lack of access to resources made decision-making and provision of services more difficult. Social work OOH teams seemed most affected by this. Present arrangements in two of the three local authorities lacked organisational support in terms of access to information or professional assistance from managers. Some instances had the potential to put a social worker at risk when attending a call-out for instance, if violent behaviour was an issue or a client was being processed through the adult protection system:

> *'A common-sense approach was their best guide to appropriate action in most cases, which in such a sensitive and litigious field left many feeling unsupported. One member said "I can arrive at a crisis scene, have little or no background information, I then have to rely on what information I can get hold of at the scene and more often than not, I'm never quite sure what to do in cases like these". She was referring to grey areas of someone being at risk of harm versus lifestyle choices. Additionally, events such as emergency respite can only be authorised by service managers however there is no rota in [name of locality] to state who is on call for OOH teams. It turns out duty workers call every manager on a list until they get to someone who answers their phone.' (Fieldnote, Site 1, P102, Social Worker, Wednesday, 24/04/2016).*

A lack of support was not confined to OOH teams. Social workers in smaller or rural localities expressed views over the absence of organisational infrastructure. For instance, one particular semi-rural locality employed just one administrator who worked part-time. This meant social work staff manned telephone calls during clerical absence. The electronic administrative calendar was accessible to clerical staff only which resulted in breakdowns of operation when attempting to co-ordinate appointments as demonstrated below:

> *'[Name of social worker] needed to confirm an urgent multidisciplinary appointment for a co-worker between social work, a client, mental health team and housing. The admin worker was out of the office for the day therefore [name of social worker] could not access the electronic calendar to inform involved parties. I watched as she spent 2 hours dealing with a 4-*

way conversation in an attempt to resolve the situation.' [Name of social worker] felt this situation was unnecessary as a duty worker and access to the administrative system would have meant that this situation would never occur. (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).

There was often a lack of infrastructure to enable staff to collect data in a timely and accurate fashion. One local authority reverted to browsing obituary sections of local newspapers to check deaths against client lists. No formal procedures were in place to collect this information resulting unnecessary service wastage:

'You know, there was somebody who was getting meals but they'd been dead for 6 months. Things like that. Em, so we are in the process of em, kinda getting things up to date. But, I think it's probably going as, I think it's chasing up paperwork from care managers, but then they're busy.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).

During interviews and observations there was a clear use of different terminology between and within health and social care. Language differences such as referring to patient/client/service user, social worker/care manager, assessor/support worker, outcomes focused/self-directed were expressed synonymously to make meaning in the workplace. Medical symbols were often used which were invariably alien to social work staff. Differences often caused misunderstandings and confusion [(335)]. Assessment procedures between health and social care were not aligned where duplication of work resulted due to different terminology and IT systems. Resources were pointlessly misused at a time when public funding was already stretched:

'I mean you do get the duplication effort was what we described it. Happens more now between health and social care. We've both went out to do an assessment on the same client. OT, to get their elements of input, to get our element of it and it's the same bloody assessment. We've actually tested it and we pulled both assessments. Yes, we talk in a different language, but we wrote the same things. So, if we can sort the language bit.' (Interview, Site 3, P301, Data Manager, Friday, 19/05/2017).

It is well documented that humour is often used in context as a tool to mitigate but also to enhance a variety of phenomena. For instance, humour is thought to play an important role in emotional management and to help relieve stress [336-338]; to assist in the development of social and professional identity [339]; to resolve conflict [340]; to maintain, manage and change boundaries [341]; and to build resilience [342, 343]. According to Lingard, silence is as important as humour, inextricably linked as language practices expressed in moments of tension or conflict, in establishing identity and in bolstering strength of character [344]. Many social workers were exposed to all of the above scenarios at some point during the study and communicated humour and silence as mechanisms to make meaning in their social world. The following extract from field notes illustrates silence and humour. Silence is portrayed as an 'empowered action' of being silent (as opposed to being silenced) whereas humour mediated shared experiences, representing a display of inclusiveness during routine practice [344 p.43]:

> *'[Name of social worker] sounded stressed and her voice was raised to a level and tone I hadn't heard before. She was shouting at [name of 2 colleagues] about how she was trying to sort her work-load before going on holiday next week. 'I don't know how I'm going to get it all done', waving her arms about as she yelled. [Name of colleague] suggested she talk to [name of team leader] about her work load [team leader was not in the office]. 'And what's happening about the new recruit?' she shouted. I wrote in my notebook '[Name of social worker] having a mini meltdown'. The atmosphere felt tense. The office went silent and I felt awkward. I kept my head down and just listened and wrote. After a few minutes [name of social worker] came over to me and said she didn't think she would have time to attend the ECS (Enhanced Community Support) meeting [to which I was accompanying her]. I told her it was ok and not to worry. I felt for her, she seemed at her wits end. It turned out that on top of her normal case load, she had two complicated adult protection cases to deal with and a medication issue with another client. After a while, a couple of conversations started by other members of the team. A bit of humour was injected which seemed to diffuse the tense mood. [Names of 3 colleagues] talked about nose rings and tattoos, keeping [name of social worker] involved along the way. I noticed her colleagues rallied round to support her. [Name of social worker] offered*

to take the ECS meeting for her. A few moments' later Sky technicians were in the building seeing to some cable work. I noticed [name of social worker] having some friendly banter with them – she seemed more settled now. Later she apologised for her outburst, and the short notice of having to renege on our arrangement to attend the ECS meeting, but I told her it was okay and no need to apologise. (Fieldnote, Site 3, P308, Social Worker, Monday, 04/09/2017).

Different narratives were attributed to different concepts of governance between health and social care creating a need for a unified approach, for example, patient/client safety. Each organisation had their own definition and approach and according to Scott and colleagues, each bore merit but neither were without gaps or grey areas (table 7) [(335)]. This might explain why most social workers felt that health care staff were risk averse since blame following failings or drops in standards expected by modern health and social care would be attached to the organisation or professional rather than being a shared responsibility as the following table by Scott and colleagues below depicts [(335 p.6)].

Table 7. Representation of Scott *et al* and their comparison of approaches between safety in health and social care [335 p.6]

	Health Care	Social Care
Predominant approach to safety	Identifying and learning from active failures and latent conditions to foster local and organisational change. Harm is understood on a systemic level with harm originating from system failures.	Risk management is applied to individuals with an emphasis on professional assessment of risk and vulnerability. Harm is understood as a serious event occurring to an individual, with risk of harm originating from the client themselves, their setting or from individual professional neglect and abuse.
Responsibility for safety	Responsibility for safety is held primarily with the system or professional.	Responsibility for safety is shared between clients and professionals.
Effects	Emphasis is placed on a 'just' culture and on organisational learning.	Emphasis is placed on discipline and the legal consequences of harm.
Implications of having different approaches to safety	1. Barriers to working across health and social care boundaries are reinforced due to differences in governance arrangements for safety. 2. Limited ability for health and social care services to learn from each other or to learn together about safety incidents. 3. Safety agendas will remain parallel, unconnected fields resulting in a lack of shared understanding of safety and harm.	

Policies and procedures intended to facilitate smooth and efficient work flow in day to day practice were not always realised on the ground. For example, cross border patients were at a distinct disadvantage since transfer of documents from one local authority to another or from a GP out with the local authority district were not straightforward, delaying client care journeys. Additionally, local authority policies were not able to maximise funds in some areas due to inadequate monitoring and auditing procedures. The decision for local authorities' to contract private care companies to attend to personal home care instead of enlisting local authority employed staff brought substantial savings. However, many expressed concern over disparities. Issues such as a

lack of communication, high staff turnover, poor training, contractual arrangement violations and substandard care delivery were conveyed. On the other hand, many were complimentary, noting that private care companies' flexible approach to care particularly with medication prompting. However, whilst some saw this as an advantage, others communicated concerns over patient safety. Client/patient safety governance was viewed differently between health and social care organisations adding another layer to the complexities of integration.

8.8. Training

Social workers at one local authority commented on a lack of clarity and formal guidance when completing the mandatory forms as part of assessing and providing services to clients. Some forms confused workers as options presented were perceived as ambiguous, blurring meaning. Information was subsequently submitted incorrectly leading to delays in processing client assessments and other reports potentially delaying client care. These types of remarks were made more often from localities who did not provide training to new arrivals than those who did:

> *'Staff change that much in the teams and there's no like, em, training, you know. When you start on your first day as a social worker, you're not told, ok, these are all the forms you have to fill in for different things you might want to do with someone. We don't have a training expert on [name of IT system]. We did have one years ago, about 9 years ago em, but that post was stopped, so there's no one that we can phone up and say we have someone new, can you come and show them [name of IT system]. They just pick up things as they go. So, the information that the clerical staff get isn't always right.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

At this particular local authority, almost all staff who arrived into new positions mentioned the lack of training. Introduction to procedures and IT systems were in the form of being presented with the likes of: *'We get them a login. [Laughs] We say, 'there's your login, off you go'. (Interview, P106, Administrative Manager, Tuesday, 15/03/2016).* New workers were normally given a lighter case-load until they settled into

the role however, this may have been further accelerated through structured training sessions:

> *'After lunch I asked [name of social worker] how she coped without [names of 2 IT systems] training. She said it wasn't easy. She would ask colleagues or her team manager when she became stuck. She mentioned one of the admin workers who was really helpful. [Name of administrator] had worked for the council for many years and as [name of social worker] said 'knew [name of IT system] like the back of her hand'. [Name of administrator] created shortcuts on the worker's desktop to make it easier for her to locate forms 'she's been great'. She kept saying 'There's* ***soooooo*** *many forms (emphasis in the original).' (Fieldnote, Site 1, P105, Social Worker, Wednesday, 16/03/2016).*

The absence of training prevented workers at all levels from gaining knowledge to maximise systems functionality. The dearth in know-how restricted staff in ways to capitalise on more efficient ways of working:

> *'There's no set [name of local authority IT system] training. So, you know, some people don't know what it can actually do, and maybe what reports you can run.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

One local authority provided induction packs for newcomers who then shadowed other social workers until they were gradually acquainted with procedures and systems. No issues emerged in this particular local authority however, most staff in departments that were observed had served for a number of years meaning new staff were few and far between:

> *'Yeah, yeah, we just sit with them and they shadow us for a couple of weeks and get familiar with all the jargon of the referral forms. And when they get cases, we work with them. We co-work the cases and guide them through the process a couple of times. I would say 2 or 3 weeks they start getting 1 or 2 easy cases, yeah, and then we supervise them with their cases. And when*

they get familiar with all the processes, then the more they do.' (Interview, Site 2, P203, Social Worker, Thursday, 06/10/2016).

Even in this authority where staff were experienced and long serving, they were staggered to find out just how much their IT system could do during ad hoc visits by IT staff:

'Yes, we had eh, em when [name of engineer] from [name of IT development company] was here, em doing a health check, his knowledge of [name of local authority IT system), it taught us so much that we're not using that system to our capacity, and it would be great if maybe once in a blue moon, that they could come down and just sit with us while we're working. Em, for us to say, oh, could you show me how to do this, or what can I do with this document. He was here 2 hours and we learnt a great deal.' (Interview, Site 2, P203, Social Worker, Thursday, 06/10/2017).

The remaining local authority also provided training which eased new workers into their role steadily. No issues were highlighted here and most seemed satisfied with the level of training received certainly in terms of when they first took up their post. Ongoing training regarding IT system enhancements was also provided but less successfully and this is discussed in the next section. Some workers found implementing new enhancements difficult as using new procedures took some time to embed into practice. There were comments around not being able to remember what they were taught during workshops and this sometimes caused delays in processing information. At other times, staff were aware of changes but would become distracted and then forget to deploy the new measures:

'The new system also operates a time-out. If a social worker does not use her keyboard within a specific time-line, they are timed-out. Any unsaved work is lost. This is a problem for staff as they often get interrupted by the telephone, they may be distracted for a while only to find out that work they had completed over a lengthy period is lost if they don't remember to hit the 'save' key.' (Fieldnote, Site 3, P305, Social Worker, Thursday, 24/08/2017).

Trainee social workers are obliged to undertake statutory assessed placements in the field as part of their teaching programme amounting to 180 days over 2 years. However, there has been a marked reduction in local authority assignments due to departments being unable to provide time to students as a result of service pressures. Placements have been absorbed by the voluntary sector and private care homes. The knock-on-effect limits trainee worker knowledge and understanding of operating within local authorities so that when they eventually gain employment they move into a totally alien environment:

> *'So, when we come to employ social workers and if those are newly qualified social workers applying, what we're finding is that some of those are people have never worked in local authority social services. Their work placements have been in the 3rd and independent sectors.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

Staff made comments regarding training new workers with mixed views. Some were comfortable training newcomers appreciating the importance of coaching, whilst others became fatigued with the additional burden resulting in extensive time to recuperate not withstanding other colleagues having to take on their existing case-work:

> *'I spoke to the social worker who had a major role in supporting a new worker and she said: "It was exciting getting a new member of staff and I felt I invested a lot of time and energy only for the worker to leave to gain a full-time position. I felt exhausted and burned out at the time taken to train a newly qualified social worker." She also divulged she had to take 5 months off work due to the culmination of increased work pressures. (Fieldnote, Site 2, P206, Social Worker, Tuesday, 20/06/2017).*

Different training issues were expressed by almost all social workers, but most vociferously when referring to new recruits or when taking up a new position themselves. A lack of formal instruction in how to use local forms, operate IT systems and in understanding local procedures in one particular authority led to numerous errors in routine work practice, but these were subsequently limited through individual improvisation. Even where training was reported adequately in the other two local

authorities, some workers were astonished to learn the wide range of functions their IT system could perform, but which only came to light through a chance visit by an IT engineer. Training was viewed vital to enable smooth operational practice and it seems there is much that could be implemented to improve local knowledge and understanding especially with regard to new employees.

8.9. Supervision and Continuing Professional Development (CPD)

Supervision is normally a period of time where staff meet with their line or service manager and are offered a safe space to reflect upon their personal work experiences and to air any tensions or concerns they may have. And although there were examples where staff remarked on finding such supervision satisfactory, having received supported guidance, there were instances where supervision was focused more from an operational perspective to the detriment of reflexivity. So, for instance, some meetings consisted of a line manager asking, what's happening with Mrs. A, where's the report for Mr. B, and how are you getting on with Mrs. C and so on. So, at a time where reflexivity is even more important due to increased numbers, complexity and case-load pressures, it seemed to be one of the first type of guidance to be neglected. And that was a real challenge for some social workers, and not just newly qualified practitioners:

> *'So, some, some have been able to talk with me very clearly about really good regular supervision, a good early kinda CPD plan about what training and other ways of learning they need support in that first year, and have felt very well supported in their first year in practice. Em, and that might come because they're in a more stable team where there might be more experienced staff there, somebody who can act as a mentor to them and a manager who's been there some time and is feeling reasonably on top of things. And other teams where there's perhaps a high turnover of staff, a lot of newly qualified workers in the team, em, that will inevitably have a knock-on effect, a negative impact on them in terms of regularity of supervision and protected work load.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

Some more senior social workers felt it was their responsibility to raise any practice concerns they had and more often than not they did not need to use supervision for that.

Others felt supervision was adequate however it was a challenge trying to gain a balance between CPD and looking after their clients:

> *'I met up with [name of social worker] later and asked how she managed her CPD training amidst her caseload. She said she did CPD when she could but this was proving more and more difficult. She explained that the onus lies with the worker to book training but she felt guilty and stressed at leaving her cases that needed attending to. She was always behind with training. I learned she would like to study more but she emphasised she was already mentally exhausted and didn't feel she had the energy, head space or time. Also, she said she needed to keep what energy she had for her clients and admitted she had a fear of missing something because of service pressures. During the conversation, [name of social worker] mentioned she had not received an appraisal for over 5-6 years. She doesn't know why, but felt she was too busy to query and concluded "I must be doing ok otherwise they would've had me in." (Fieldnote, Site 2, P206, Social Worker, Thursday, 22/06/2017).*

Social work staff were being asked time and time again to think of more imaginative and novel ways of working [(345)]. Whilst there was a willingness by almost all members to engage, organisations did not provide the environment to generate or inspire creativity:

> *'When I think of some of the bits that we've been encouraged. On the one hand is to be more creative, and thinking about community engagement and partnerships. But people aren't getting the space to do that. So, people can be very enthused about that in training and learning, and team development stuff and create lots of stuff. But it's about getting the chance to do that.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

Retention of staff seemed to be an issue in some social work departments where staff mentioned workers would resign to take up social work agency positions (bank staff) because of increased work pressures. Bank staff worked temporarily and were relieved of normal case-load burdens which although brought benefits to the individual social

worker, added instability to permanent team members. Consequently, some less experienced workers were assigned more complex cases than their knowledge or time served merited, leading to differences in their decision-making and design of a care package. Best use of resources was not always achieved:

> *'The differences might be around em, newly qualified workers not knowing enough about the resources and the local community. So, their recommendations might look different to those of a worker who can be quite creative because they're very involved in their local community and can see and can kinda be a bit more creative about that.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

The above example helps to demonstrate that the decisions made in a social worker's role are not cut and dried. A social worker's aim to meet client need can involve a number of different feasible options to achieve these and are contingent on contextual permutations of who, where, what and how. In the majority of cases, different practices resulted in similar outcomes. This was observed throughout the study. For example, at one particular workshop, social workers were each given the same group of scenarios and asked to decide what measures they would take to resolve. When discussing each approach afterwards, similar outcomes were achieved in each assignment albeit through a range of different means.

Differences in finding solutions to similar instances also occurred in a study that investigated the early implementation of the Quality Outcomes Framework (QOF) contract in GP practices. GPs used different processes and systems to meet similar QOF targets [(346)]. Additionally, a rather entertaining piece of research reported by psychologist Sharissa Bradley offered 250 ways to wash dishes [(347)]. The research carried out by Virginia Satir suggests more than one right way to do anything. If such a simple task as such as doing the washing up can have so many alternatives, then it is no wonder the complexities of health and social care solutions can come in many shapes and forms to meet client need.

Supervision and CPD were considered important properties and platforms to facilitate reflection, new learning and development opportunities, particularly for newly qualified staff. Social workers and their managers were under increased work pressure which threatened to undermine the regularity of the practice and ultimately devalue its worth.

8.10. Summary

Organisational factors that influenced routine collection, processing and management of social care information have been described in this chapter. Each section highlighted complex and dynamic organisational structures which in part have made great strides to streamline data process in support of health and social care integration. Some organisational infrastructures provided the environment to enable collaborative working such as co-location, joint working ventures and regular MDT meetings, bringing absolute integration closer to the government's 2020 vision. It is important to reiterate that some local authorities were more developed than others. For example, some councils were more advanced in IT expertise than their counterparts. Similarly, management styles differed between departments within and across localities. Equally, local authority premises and staff working environments varied in provision of facilities and resources. In the same vein, some local authorities were forced to charge clients for equipment whilst others offered equipment free. Each local authority had strengths and weaknesses in all areas of organisational systems, but no one council was overall more advanced than the others.

It was found that deviation from policy mandates helped smooth care pathways where concerns around organisational barriers were ameliorated through soft skills, co-operation and strong leadership. Clarity of direction through applying these skills also helped partnership working impacting positively on client outcomes and staff morale. A lack of these important qualities led to the delivery of fragmented services and dissatisfaction from staff. The chapter also illustrated how there seemed to be a lack of readiness to address issues for example, employment terms and conditions, unequal opportunities for career advancement, lack of training/CPD and disproportionate budget constraints during these challenging and ongoing times of austerity. These inequalities have led to many social care staff feeling undervalued, insecure and subservient to perceived elevated health colleague status preventing the success of some joint working activities. If absolute health and social care integration is to prove successful, a

determined effort will have to be made to address such divisive and potentially toxic measures.

Having clarified the many strengths and weaknesses attributed to organisational systems, the next chapter examines professional power, identity and boundary-work. The chapter seeks to cast light on professional forces at work which influence data collection and management process in integrated care. Thus, the chapter investigates dynamics between social workers and health staff, social workers and the administrative staff whom they work alongside and social workers who work together during the course of their everyday work experiences.

9. CHAPTER 9. THEME 4 – INTER/INTRA-PROFESSIONAL RELATIONSHIPS

9.1. Introduction

The previous chapter examined organisational aspects of social care data processes and factors that influenced the multi-dimensional processing and management of social care information. This chapter presents the fourth main theme that emerged from analysis, inter/intra-professional relationships between health and social care staff, incorporating; power dynamics, professional identity and boundary work. The chapter explains how these concepts are integral to health and social care information processes and the ways in which they are responsible for creating, maintaining and altering the very dynamics of the processes themselves.

A crucial dimension of this chapter is the way in which health and social care professionals share some common values but that these were established through respective discipline priorities that were often in opposition causing mutual tensions. The chapter begins with an overview of power dynamics in the health and social care domain from the perspective of social care. Drawing from Freidson's work on professions and professional dominance, this section highlights social workers' experiences and position within this hierarchal field [255, 263]. The chapter then examines professional identity and factors that shape routine practices between health and social care staff. Consideration is also given to how inter/intra professional boundary work occurs and further evolves. Professional boundaries; a process defined by Anselm Strauss about borders or limits around a profession, differentiating what can and cannot be performed by specific occupations, will be explored using his negotiated order perspective [262]. The chapter also takes account of Gieryn's understandings of how boundary work intensifies during political, economic or organisational change, where boundary-making and boundary-blurring are in a constant state of change, adding a further dimension to the analysis [271]. Findings help to explain opportunities and challenges faced by health and social care staff during joint care undertakings.

9.2. Power Dynamics between Health and Social Care Staff

This section examines different power dynamics between health and social care staff from a social care perspective. The sociology of the professions theory offers the

conceptual tool to examine these inter and intra-professional relationships of high and low status staff and to make meaning of the complex structures of social care data processes and management [254, 255, 258, 260]. This approach has been applied as it became apparent during the course of the project that social workers interacted with a variety of professional groups whilst carrying out their routine duties; gathering and managing client information both internal and external to their domain. According to Freidson's classic sociological writings on professions and healthcare professions in particular, a 'hierarchy of institutionalised expertise' exists where nurses and social workers are considered subordinate to clinicians and other medical staff [263 p.137]. Holding supreme authority affords power and control over financial matters, the distribution of resources and the division of labour.

Nugus and colleagues observed case conferences that reflected two models of power between doctors, nurses, AHPs and social work staff when determining patient care management; authoritatively or through 'collegial facilitation' [348 p.901]. Doctors either chaired or dominated processes in the authoritative model, perceiving the responsibility of patient care ultimately lay in their hands. Decisions were made through evaluating input from other professionals, suggesting a socialised expectation that doctors could accept or reject other professional contributions. This type of care management occurred mostly in acute settings. Collegial facilitation case conferences on the other hand were chaired by medical staff in a collaborative manner, encouraging participation from other members rather than the orderly invitation by a doctor in the authoritative model. This model took place more in community settings [348]. Studying power being exercised in relation to these dynamics may contribute an understanding of data collection and management processes between health and social care staff, which is believed unreported thus far in Scotland.

Some authors cite 'local' and 'insider' statuses between health and social care staff as being influential factors to address power imbalances [349]. These conditions are not fixed and are ever changing. For example, Powel and colleagues demonstrated how local standing among social workers (as opposed to outsider) could be 'earned' and improved over time particularly through developing relations with others already judged 'local' [349 p.571]. Similarly, those social workers considered outsiders were able to shift the balance of power through approving word of mouth rhetoric from insiders, represented

as 'earning one's stripes' [349 p.573]. Accepting this case, it is also reasonable to assume that poor professional relationships and negative expressions may also impact the fluidity of power dynamics.

In hospital and community settings, doctors can be viewed as holding more power than nurses, AHPs and social work staff due to the higher status of their profession [255, 260, 350]. Traditionally, doctors dominated the medical landscape by virtue of their control of knowledge and social position [267]. It is important to point out however, much less power is afforded than in previous decades. For instance, doctors in the UK are now subject to more state control, limiting their autonomy [350]. Additionally, increased nursing/AHP/social work staff skill sets and organisational re-structuring allow previously lower status occupations to challenge care decisions [350]. However, this study found clinical evaluations often continued to dominate processes, their decisions competing with other difficult organisational pressures and priorities such as delayed discharges. In acute settings in particular, social work comprised a small department with minimal power limiting their ability to have their voice heard. These conflicts diluted true person-centred care in contrast to the aims of social work principles causing friction and anxiety amongst social care staff:

> *'She was saying, 'but the way I should be working and have been working with the woman [palliative] and her family is about looking at her outcomes, and that was her wish to die at home. And I resisted this bit [consultant's decision to transfer to a care home] about just trying to get her somewhere in the meantime.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

Other instances of power forces at work involved OOH staff who reported a similar rhetoric from doctors exerting power:

> *'Medics called OOH **demanding** emergency respite for a patient in order to free a hospital bed – despite other procedures in existence to handle hospital discharges (emphasis in the original).' (Fieldnote, Site 1, P102, Social Worker, Wednesday, 24/02/2016).*

Most comments from front-line social care staff refereed to them being undermined, marginalised by, or subordinate to health care staff during joint working. This reflects what Bourdieu conceptualised as 'social capital', a form of power related to affording credence to mutual membership of a family, club or group and their standing in society [(351 p. 248)]. According to Bourdieu, the amount of social capital occupied by a group depends on the size of its networks and its capacity to influence and secure resources or membership to ultimately expand and preserve the group. Health care can be viewed as a powerful network, certainly in relation to the much smaller social work organisation. Equally, health staff were viewed more favourably by the general public than what seemed the villainised social worker [(92)]. As a result, social workers faced many challenges and disputes over care management decisions, despite being able to promote better outcomes through a high level of understanding beyond immediate medical concerns. Their broad focus and nuanced knowledge of their clients, families, and social dynamics meant they were often better placed to make judgements in care planning. Pressurised acute services with a managerial focus on discharge meant that tensions soon emerged between clinicians, nursing and social work staff during the assessment process. Social work values were regularly undermined:

> *'[Name of social worker] assessed a particular client with a package of care that would enable the client to remain at home. The client's consultant disagreed suggesting a care home instead. [Name of social worker] found this type of scenario happened often and claimed medical staff were sometimes overly risk averse and not person-centred enough. She told me about the numerous instances where she would have to defend her assessment and judgements to her team leader and service manager. After inspection, her assessments were always accepted as an accurate reflection of the client and the decisions made around him/her.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).*

In hospital settings, there was a distinct tendency for clients to take advice from health care staff than from a social worker when plans were being made for discharge. If there was a difference in opinion for example, if a clinician recommended admission to a care home and a social worker proposed a package of care, the clinician's recommendation would almost always be chosen irrespective of the client's own wishes. This then caused

conflict and anxiety between clients and families/carers, not least because client assessment findings more often than not fell below the criteria required for local authority assistance with care home funding. More importantly, clinical status took precedence over appropriate client wishes and care need. Freidson hypothesised this as 'professional dominance' attributed to doctors who were viewed as holding comprehensive and special knowledge above that of subordinates and laypeople [263 p.128]. In some cases, nurses' views also took precedence over social work assessments:

> *'So, if the nurse says or the doctor says, then they [clients] will go with that and that becomes the trump card if you like. There's definitely a difference, it's not equal in terms of assessment.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

Some comments were surprising where clinical staff overruled client statements showing it was not just social workers whose views were questioned or disregarded in the hierarchy of health and social care:

> *'Another issue that struck me was from a comment made by a consultant when referring to a patient during an MDT meeting. 'She doesn't have all the symptoms she says she has'. I am mindful I am not a qualified medic and I was involved in a snapshot of just one meeting. But the tone of the consultant's voice surprised me and made me think there was little consideration for the patient's view. It seemed that because **he** felt there were no symptoms, then there were no symptoms (emphasis in the original). I mentioned this to [name of social worker] afterwards and she said, 'I know, he's normally really good', [meaning the consultant].' (Fieldnote, Site 1, P109, Social Worker, Tuesday, 05/04/2016).*

Both health and social care staff viewed co-location as a positive approach in order to move closer to absolute health and social care integration. However, as noted by Carey, there was a sense of professional fear in that social care staff felt they were in danger of being subsumed into the much larger and more powerful health sector [352]. Social care staff further feared the risk of the total disappearance of social work as a profession. Other staff felt similarly, although explained their rationale differently:

'As it stands at the moment, district nurses are located at medical practices throughout the district. On the face of it, this seems to make sense. They are in a medical environment, delivering medical care. However, [name of social worker] suggests that care is becoming more socially driven than medical therefore, she feels it would be better if healthcare staff were located within social care teams. In addition, she felt that when nurses were removed from a medical environment, their attitudes changed. I asked what she meant and her response was very interesting. She felt that medical staff were very hierarchal within their practice and operated under a rigid organisation which she thought provided power. However, when removed from that situation, but still doing the same job, power was less of an influence and a more common-sense approach took over.' (Fieldnote, Site 2, P206, Social Worker, Thursday 13/04/2017).

In-group/out-group attitudes were evident when observing access to information. Health staff co-operated with co-located social work staff to obtain information on their behalf. Successful access to data was largely due to in-group health care knowledge alongside requests being processed through other in-group colleagues:

'Yeah, some of these people, he knows who to speak to, but I think some of it comes also from the fact because he works for NHS.' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).

Power dynamics between health and social care were apparent throughout the study albeit they were more prominent in hospital settings. Freidson's writings help to explain the hierarchal status between health staff and social workers. Greater clinical status (perceived or actual) sometimes led to concerns and misgivings during integrated client care decision pathways.

9.3. Professional Identity

According to Ibarra, professional identity is a concept whereby people associate with attitudes, values and beliefs of a professional group and where they compare, differentiate and define their profession from other professional groups [(275)]. Professional

identity is considered to hold intrinsic worth and is part of personal identity where individuals define their identity within and across professions [350]. Along similar lines, professions are described by Abbot as organisations or groups with a list of attributes or traits that lay claim to a specific 'jurisdiction'; in other words, the right to dominate a particular area of work [276 p. 551].

From a health and social care perspective, care is delivered by a wide range of staff incorporating hospital and community doctors, GPs, nurses, AHPs, managers, social workers, carers and administrators. How they achieve their aims are largely dependent upon their professional identity, ethos and role [273]. Social work is defined by the British Association of Social Workers as having a distinct and unique history [353]. The discipline incorporates its principles and values into practice through promoting empowerment, independence, self-management and in balancing need versus risk whilst also recognising human rights [353]. The profession has not been static, rather it has continued to evolve from its charitable and voluntary beginnings to its current regulated and formal structure [256]. Like all professions, shifts in social trends and responses from governments through political, economic and social policies have ensured that it is always in a state of flux. This section discusses how the professional identity of social care staff influenced information processes and care management decisions obtained from observations, supporting interviews and supplementary documents gathered throughout the study.

Almost all social workers who worked alongside health professionals at grass roots level made reference to their professional identity in the wider scheme of health and social care integration. Although, it was interesting to note that where there was less frequent interaction between social care staff and different disciplines, there was less propensity to define professional identity. For instance, staff who were office-based or not in direct contact or co-located with other agencies did not mention professional similarities or differences as much as those who were, and this was consistent across all local authorities.

According to Hudson, social workers are socialised into their profession [350]. Formal socialisation begins through completion of a university or college course, pre-qualification placement and subsequent registration with governing bodies. Informal

socialisation is an ongoing process that transfers formal learning into practice but also through learning norms, traditions and roles during successive positions and tasks. Within social work departments, team leaders have the opportunity to shape team practice through guidance, motivation and enthusiasm to enable strong mentorship and high performance even when wider organisational and external pressures are challenging. Staff experiences with team leaders influence routine practice, ultimately shaping work standards, performance and recording behaviours through mirroring [(350)]. This was noticeable during observations particularly where one large department retained many team leaders and whose workers imitated their respective leader's practice style:

> *'I think the way the team managers are bleeds down to the, to the workers and you get workers who you could guess what team that person was in because of the way they work.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

Satisfaction with supervision is viewed as a means to strengthen a social worker's professional identity and the development of professional skills [(354)]. Whilst there was evidence to support excellent guidance on various occasions there were however, worrying instances where supervision was not well provided leaving workers feeling vulnerable:

> *'But what a lot of these workers, they'll say, I'm not getting enough supervision, I'm having to grab my manager to make these decisions, you know, I'm not really getting the space to talk about how this is affecting the service user and their family, and how it's impacting me. So, this thing's all building, kinda tension and upset. Em, but they are also very aware of the pressures that their line manager is under. And em, because of the nature of the work they're in, they're concerned for managers as well. And that's not right. So, it's that bit about how do we get to a place where we're saying, no it's absolutely critical that people have that regularity of supervision and the opportunity to kind of look at the decision-making they're involved in and also the impact of the work on themselves.' (Interview, Site 3, P302, Social Services Manager, Monday, 29/05/2017).*

Some situations led social workers to question their own and other professional identities. Scenarios that occurred were incongruent with some of the shared values health and social care staff adopted, but which competed with other hospital priorities. Statements such as 'discharge is king' and 'keep acute beds flowing' were often voiced reinforcing opposing patterns of working. *(Fieldnote, Site 1, P109, Social Worker, Tuesday, 05/04/2016):*

> *'But just now people **don't actually care** (emphasis in the original). They don't care if you go out tomorrow and a failed discharge. Because you're out and you're off the ward, and that's another stat somewhere, somewhere else. Because somebody'll be standing saying 'that's great, we've got 2 beds' and not even remember who you were. That's not good. We had somebody the other day who was boarded [10] to another ward. The ward discharged them. Social work were waiting for a care package. They [ward staff] said the person discharged them self. The person didn't discharge himself. But nobody knew because he'd been, he'd just been boarded.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

Health and social care partnership members made reference to a lack of group identity resulting from their newfound affiliation. Identity seemed to be an important factor in how the group functioned as a whole. There was a recognition that new groups involving different professionals took time to develop innovative ways of working but that power from upper management also impacted their ability to bring about change:

> *'Now, I think there are other changes that need to come and I think some of these changes are about the fact that what's the identity of the partnership? Actually ok, in legal terms it's a partnership and it can act and it's got devolved functions. But they're only devolved as much as the partner organisation will allow it to devolve. So, there's still, they've still got a hold on what we can and can't do, to some extent. It might be direct, it might be*

[10] There are different definitions to a boarded patient. This context refers to a patient who is categorised as an inpatient however, they may not be assigned to a ward that relates to their medical condition due to a lack of inpatient beds. Boarding normally occurs to help with overcrowding in emergency departments or to maintain operational flow.

indirect; they might do it in other ways to influence the change. But we're still held through that and that's where you're thinking, well is that a good thing or a bad thing? And we don't know, you know. Most of us are a year in, well we're coming to the first year of health and social care partnership. So, it'll be interesting to see what the national picture brings from, you know, everybody.' (Interview, Site 2, P205, Data Manager, Thursday, 09/03/2017).

The concept of professional identity appeared important to social work staff, particularly when working jointly with healthcare staff. This may have been because joint working had highlighted other professional values and practices, some of which were shared, whilst other principles and beliefs were found to be incongruent. Controversial situations during the care decision process caused social workers to question their identity when other health priorities superseded, leading to a sense of ineptness at times. Supervision and strong leadership helped to strengthen and shape professional identity and to encourage best practice.

9.4. Inter/Intra-professional Boundary-work

Much of the literature that explores professions refer to their emergence as being created through strategies and techniques deployed by individuals or groups to lay claim and control over a particular field of knowledge [255, 260]. Described as a 'labour of division' by Fournier, the process establishes order, exclusivity and prestige in the boundaries between professions and other occupations [272 part II, chapter 4]. The now classic work from Thomas Gieryn refers to the concept of boundary-work or divisions between professional ideologies, values and knowledge bases and how these are created, challenged or strengthened [271, 272]. Also termed demarcation, the process relates to borders or limits around a profession, differentiating what can and cannot be performed by specific occupations through knowledge and skill [271, 272].

Boundary-making is conceptualised by Strauss *et al* as a processual view of 'negotiated order' [262 p. 147]. The model distinguishes macro-level social and organisational structures (structural contexts) and every day micro-level processes and practices (negotiation contexts) [262, 269]. According to Strauss, different occupations incorporating different training, status and ideology worked alongside each other and created patterned order through a continuous and complex negotiation processes which was not accidental

or fixed and altered over time in context of each situation [262]. Social order is thus contingent on organisational structures which set the scene and position from which individuals negotiate on a daily basis to shape and re-shape routine work.

Strauss's extensive work in two psychiatric hospitals found neurology or psychotherapy trained psychiatrists and senior nursing staff would come to an understanding during ward allocation of patients. Neurology minded psychiatrists recommended what was known as the 'house special' to differentiate between somatic (electric shock) and psychotherapeutic treatment wards. This meant nurses knew exactly which ward the psychiatrist recommended with no further instructions needed [262 p.161]. Additionally, psychiatrists would reach a nodding agreement with nursing staff in how to handle a new patient in a particular way or to agree to ignore an established hospital rule for the benefit of a patient. Strauss also observed that if psychiatrists were obstinate or troublesome, for instance, using hospital programmes or resources in unsatisfactory ways, nurses and administrators would bring senior staff into the equation to negotiate further support to negate disorder. These actions were found to be greatly predictable, albeit sometimes implicit, sometimes tacit, but always temporary and would alter when regular staff or situations changed which brought about new negotiations to re-appraise, re-establish or revoke agreements.

Gieryn suggests that when professions experience uncertainties or strains, boundary work, intensifies whether aiming to expand, monopolise or protect respective disciplines [271]. Abbott described these as a series of 'turf wars', a dynamic mix of ever changing and contested boundaries [276 p.552] Anne Witz describes these interactions as occupational closure strategies that enable claim to opportunities or resources [355]. The model comprises four distinct channels between; 'inclusionary, exclusionary, demarcation and dual closure' strategies [245 p.45]. The approach adopted would depend on whether a group or individual was enacting from a position of power or subordination [355]. For example, dominant social groups or occupations would engage in exclusionary and demarcation tactics, whereas subordinate groupings would respond by employing inclusionary and dual closure approaches. Under the present flux of precarious times in health and social care organisations, Strauss, Gieryn, Abbott and Witz's insights can help shed understanding on how and why professions try to protect or expand their respective positions. For example, successive governments have shaped health and

social care where practitioners are increasingly being deployed in integrated positions [356, 357]. Staff from different disciplines are being asked to take on new roles although it seems it is not clear how these roles should be performed in everyday practice [107, 357].

Boundary-blurring builds on Strauss's work and occurs alongside boundary-making [266, 269, 272]. The strategy attempts to reduce inflexibilities in professional boundaries by crossing the very margins of occupations and by carrying out work previously deemed the duty of others. Allen observed five sub-types of what she described as 'purposive' boundary-blurring in the nurse-doctor boundary; 'continuity-orientated, articulation-orientated, judgemental, rule-orientated, lay-orientated' [266 p.511]. For example, nurses performed doctors' work to maintain the co-ordination of patient treatment in their absence [266]. In her study, she noted nurses who instigated referrals or tests based on their own judgement. Other nurses administered un-prescribed medication to patents but then would request the doctor to prescribe later [266]. Additionally, nurses were noted to request prescription drugs for patients, but were rarely questioned by medical staff. Working outside hospital rules were perceived to benefit the patient and considered by nurses as their 'jurisdictional' priority [266 p.505] .

This study examines how boundary-making and boundary-blurring was enacted between health and social care staff to effect data processes and joint working across different agencies. Whilst boundaries between doctor/nurse or doctor/administrative staff have been researched extensively over recent years, much less has been examined between health and social care staff [220, 266-270]. The next section examines this gap in the literature and focuses on how social work staff negotiated professional boundaries in everyday practice between health staff (doctor/nurse) and the administrative staff who they work alongside, as well as boundaries between social workers themselves.

From a social care perspective, to which this section is the main focus, the macro-level of boundary-making is formed initially through structures such as a four-year undergraduate or a one year post graduate degree course. The National and Scottish Vocational Qualifications (NVQ and SVQ respectively) are other pathways where all credentials are subject to mandatory registration with the Scottish Social Services Council (SSSC) regulatory body [358]. Subsequent boundary-making between health and

social care staff is established primarily through reference to government mandates, local authority policies and protocols. Boundary-making at the micro-level of order took the form of negotiation through co-operation among health and social care staff within their own profession and also across other disciplines. The following are representative of boundary work maintaining a focus from a social care perspective as follows:

9.4.1. Boundary-making by Social Workers towards Health Staff

Social work staff were observed being engaged in boundary work; agreeing tasks with health colleagues both in community and acute settings as described by Strauss [262]. For example, social workers exchanged duties with district nurses and ward staff on a regular basis in order to accommodate day to day events and by agreeing care provision. Similarly, social workers, clinical staff, GPs, OTs, pharmacists and district nurses would request profession specific information about clients during MDT meetings, enabling swift evaluation and resolve to client concerns. This was described by Allen as addressing 'organisational turbulence' in order to operate as competent teams [266 p. 506]:

> *'The MDT meeting began. Around 11 members of staff stood grouped together in an open space next to the nurse's station. A combination of consultants, junior doctors, physiotherapists, occupational therapists, nurses and nursing students were present. Some staff came and went during the meeting in an informal manner. That is to say they walked away discretely, without notice or acknowledgement, then returned in the same fashion, then departed and revisited over again in the same way. Everyone's attention was focused on a smartboard which displayed a plan of the ward with each patient assigned against their respective bed. The board also showed which consultant was responsible for which patient and also what services a patient was receiving, i.e. OT or Physiotherapy. Each person in attendance held a copy of the ward occupancy print-out, as did [name of social worker] who received it from clerical staff. The senior charge nurse orchestrated the meeting beginning with the patient at bay 1, bed 1. Once this case was concluded she then discussed the patient at bay 1, bed 2, followed by bed 3, 4 and so on. She then began with Bay 2 in the same manner, then Bay 3 and so on. Side rooms were the last group of patients to be discussed. She updated each team member on the patient's current*

condition, treatment and date of any discharge plan alongside any requirements that were needed in order to facilitate appropriate care or successful release. For instance, one patient was fit for discharge, but had been refused funding for 24hr care. Since this was a social care issue, the charge nurse looked to [name of social worker] for an update. [Name of social worker] was able to inform the meeting that the patient was out-with the [lame of local authority district] area, therefore the responsibility lay with the respective area's social work department who needed to be contacted by the ward. The meeting progressed in an orderly manner until all patients were discussed and members brought up to date with each patient. There was one patient whose name was displayed on the smartboard and listed on the medical staff's list and when it came to his summary the charge nurse looked to [name of social worker] for an update in terms of a social care package. [Name of social worker] did not have the patient listed on her sheets. Later when I asked her why this might be, she said that sometimes clerical staff print-out her sheets the day before the meeting, therefore patients arriving on the ward after that time would not show on her copy.' (Fieldnote, Site 1, P109, Social Worker, Tuesday, 05/04/2016).

In contrast, boundary-making between health and social work staff were sometimes at odds with different health and social care ideology principles, priorities and practices despite sharing some common values. For example, during observations and interviews, there was a general consensus from most social workers that district nurses in particular held the attitude of 'you need this done, rather than what can we do to help you', *(Fieldnote, Site 2, P208, Social Worker, Thursday, 22/06/2017)* resulting in conflicting views during client assessment and the provision of care. These types of actions led social workers to become guarded against nurse directed behaviour. Different philosophical viewpoints often seemed to strengthen an in-group/out-group mentality rather than cultivate inclusion and inter-agency collaboration as depicted by Dingwall [(261)]. In most circumstances, health and social care workers acknowledged the virtues of joint working ventures, MDT meetings and co-location strategies where close professional relationships developed over time, reducing divisions.

'[Name of social worker] introduced me to the team which consisted of 4 district nurses. The meeting normally lasted around 30 minutes and everyone stressed how important they felt this arrangement was. MDT's kept everyone in the loop about clients and also helped to build close relationships between health and social care staff. The department also held enablement meetings every Tuesday in addition to MDT's. Everyone at the meeting approved of the gatherings and felt it should be mandatory for all districts. It transpired only one of the three locality offices in [name of local authority district) held these meetings.' (Fieldnote, Site 2, P206, Social Worker, Thursday, 06/04/2017).

Although joint working initiatives enabled each organisation to obtain a better understanding of each other's practice, respective views were often split. Inter-agency collaborative interactions were transient, often resulting in different outcomes for different people with different professions, in time, place, and in context of each situation. For instance, health and social care staff both embraced person-centred care, although each practiced the principle from different viewpoints and priorities:

'After the visit, I accompanied [name of social worker] to [name of local health centre] for a scheduled district nurse meeting. This is where [name of social worker] and the nurses meet every Thursday at 12 o'clock to discuss any concerns they have with clients. On our journey in the car, I asked [name of social worker] if she recognised any differences between health and social care staff. She said she did, but that these predominantly stemmed from variations in professional attitudes. [Name of social worker] felt that healthcare staff found it hard to accept that people had a right to live how they wanted, even if this was detrimental to their health. Nurses found it tough seeing someone say for instance, living in a dirty house, eating poorly or drinking alcohol excessively, despite these actions being of client choice. Social work gave greater precedence to people's rights and choices. She further added "nurses are keen to do for rather than enable a person to do for them self".' (Fieldnote, Site 2, P206, Social Worker, Thursday, 06/04/2017).

On reflection, the above extract depicts the views of a social worker expressing holistic care from the principles of social care. However, health staff reading the excerpt may justifiably argue the nurse's view was also person-centred. For example, one of the main principles of nursing practice endorsed by the Royal College of Nursing is being conscientious in reporting patient situations that are of concern [359]. Consequently, a nurse attending to a patient in the home, perceiving the environment to be perilous, presenting a potential risk to an existing medical condition was thus a cause for concern. Social work would agree to the situation being less than ideal, but would regard client choice uppermost.

There was often an inability for different professions to be flexible or agree ways forward as each vied to uphold their professional stance. Client care was sometimes delayed ultimately bringing limitations to some joint working initiatives. These observations, support Gieryn's view of intensified boundary-making during precarious times and Abbott's 'turf war' contests [276 p. 552]. Staff drew superiors or line managers into equations to afford more support to their argument in what Strauss conceptualised as 'patterned variability of negotiation' [262 p.162]. In other words, every day order was based on respective ideology and position which was consistently negotiated, argued and agreed (sometimes ignored) between health and social care staff. These non-random actions were always in a state of re-negotiation in the ever changing and multi-factorial environment of health and social care organisations:

> *'The OT was reluctant to conduct the assessment saying the district nurse was already attending to catheter care therefore, it made sense for her to conduct the assessment at the next visit. This was especially since she performed the original assessment for the hoist a few weeks prior. [Name of social worker] contacted the district nurse who refused, stating the assessment was the responsibility of the OT. The OT and nurse were in dispute, each reporting they would speak to their respective line managers. I found out later that [name of social worker] called respective line managers who had still not resolved the situation. In an attempt to play devil's advocate from a roles and responsibilities perspective - a hoist assessment was traditionally deemed the duty of an OT prior to health and social care integration. However as mentioned, the nurse was already*

> *attending the client regularly, had conducted the original assessment under joint working practice, which then made sense for her to continue the process. [Name of social worker] was so frustrated at the lack of co-operation 'I wish someone would just get the damned thing done.' (Fieldnote, Site 3, P306, Social Worker, Wednesday, 23/08/2017).*

Social care staff voiced similar concerns in hospital settings where the transfer of information from wards to the social work discharge team jeopardised patient safety and care need due to a lack of information provided. This was echoed by Scott who warned that a lack of alignment in information sharing introduced the potential to hinder beneficial client outcomes [(335)]. Referral forms were almost always completed by ward staff with scant detail, frequently transmitted to hospital discharge teams with client name and ward number only. Additionally, health staff and the social work discharge team completed different versions of a referral, further complicating smooth transition. Nurses viewed delivery of a referral more important than gathering information, and viewed the latter as the role of the social worker. Ward staff working in already busy and stressful environments, considered direct patient care their priority:

> *'The nurse also mentioned that if a consultant asked a member of the ward to make a referral to social work, they would do this and not necessarily ask for any background information with the assumption that a social worker would do that.' (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).*

There were numerous occasions where differences in professional values and practices were observed between health and social care staff. For example, district nurses would telephone social work departments and request (sometimes demand) staff to initiate cleaning or other services to individuals who they believed were living in undesirable conditions. However, on such occasions services were never implemented as the first course of action. Instead, social workers were quick to point out that where lifestyle choices were unfavourable they would attempt to show clients other forms of living, referring to the approach as 'gently chipping away' *(Fieldnote, Site 2, P208, Social Worker, Thursday, 22/06/2017).* Similar comments were made when questions were

asked around differences between health and social care staff operating from hospital discharge teams:

> *'I would say there's a **big** difference, and it's that daily battle, and again, it's a different culture, probably different value based of a view that you can just do to people (emphasis in the original). So, if someone decides that that is good, they just do it. They [health staff] don't understand, they get really frustrated if somebody's gotta go down the guardianship route. They get really frustrated if you can't just tell people what to do, or just move them, because actually, this is about the person and they've got choices and rights and a right to an assessment.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

It seems differences were not only confined to health and social care staff but also within health care. Similar healthcare professions often held different views, which sometimes led to conflict. For example, differences during the decision-making process had the potential to shape a successful or failed discharge as inter-professional perceptions of risk varied:

> *'Another OT told me about differences between her profession and physiotherapy, despite being closely related in vocation. She said a physiotherapist would be more focused on somatic aspects, where as an OT was more holistic in thought process. The OT gave me an example. A physiotherapist recommended a patient for discharge as the patient could walk. The OT did an assessment and did not think the patient was fit for discharge. Yes, the patient could walk, but there were numerous barriers in the home environment which made discharge particularly unsafe.' (Fieldnote, Site 1, P109, Social Worker, Wednesday, 06/04/2016).*

Different forms of boundary work took place by social workers when working alongside health care staff. Some contested organisational mandates whilst others focused at an individual level, viewing their perception of each boundary encounter as vying to uphold respective principles and practice. Most boundary work; through mutual negotiation and agreement between practitioners was intended to aid co-ordination and care decisions.

Unfortunately, the reality on the front line was that care decisions and provision were often at risk of being implemented less than optimally from a social work perspective.

9.4.2. Boundary-making by Social Workers towards Administrative Staff

Over recent years, austerity measures and welfare reform in the UK have resulted in severe cutbacks in administrative support staff in social work departments [360, 361]. Each of the local authorities in this study had been affected by these changes, meaning that social workers had to carry out an increasing number of administrative tasks themselves. On one hand, new technologies made some administrative tasks simpler. However, these were regarded as low-status tasks by social workers, adding to the burden of increased volume and complexity in cases, causing tensions between administrative and social work staff. For example, social workers arranged duty-worker rosters, manned clerical telephones during administrator absence and updated client information on respective record management systems. Some social workers complained about spending extended periods of time carrying out mundane paperwork, taking time away from doing what they viewed as important work with clients:

> *'At that point the ladies also mentioned the increased amount of administrative work they were having to perform which they felt was an inefficient use of their time. [Name of social worker] said "you're paying someone £35 grand a year to do admin work". (Fieldnote, Site 2, P207, Social Worker, Thursday, 22/06/2017).*

Administrators on the other hand, objected to a lack of understanding shown by some social workers especially given the drastic reduction in administrative staff for instance, by almost 60% in one department, which significantly impacted on their workload.

> *'There's been tears, em, they're always busy [administrators]. The full-time girl has been here for years, you know [name of senior administrator]. Em, you know, I know that they're busy em, and I think they've quite liked having an admin person as their manager as opposed to team managers who really don't have a scooby[11] what they did. They know that things got done, but*

[11] The word 'Scooby' is rhyming slang (Scooby Doo), commonly used in Scotland to mean 'clue'.

> *they didn't know how they got done; what the priorities were. The clerical staff were just left to get on with it. (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

Most social workers were accepting of the staff reductions in administrative staff and duly completed additional administrative tasks. However, others became defiant by refusing to complete what they considered unnecessary and mundane paperwork until their own priorities were addressed.

> *'The electronic recording system is also duplicated in hard copy files. [Name of social worker] does not complete these files and states quite adamantly, 'I do not duplicate if I can help it, I just don't do it'. She told me that from time to time she gets 'hounded' by admin staff to get her files up to date. She reluctantly does this but prioritises her work load meaning that files do not get completed until she has attended to what she considers more important matters.' (Fieldnote, Site 1, P102, Social Worker, Monday, 15/02/2016).*

This caused further tensions among administrative staff since the lack of form completion delayed processes on systems for billing purposes and also in statutory government statistical returns. Some social workers viewed administrators as being of lower status and this was reflected in some team behaviour:

> *'Em, one team manager wanted one [administrator] to go over and em, he'd taken all the files out of his cupboard and put them on the floor. He wanted a clerical to pick them up and put them back in alphabetical order. I said **No**, that is not a priority (emphasis in the original). Pick up the files yourself.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

This view of lower status was reflected in the restricted levels of access available to administrators in the case management system making clear distinctions between the boundary between social workers and administrators:

> *'Yeh, we've aw got certain permissions, like we won't have access to [name of team leader] and the team or the financial assessors. But they'll probably have more access, they'll have more permissions, they'll see everything, whereas we're limited. We can only see our own little bit.' (Interview, Site 2, P201, Administrator, Monday, 04/10/2016).*

In most social work departments, specific administrators were viewed as the 'go to' people when social workers had queries relating to IT systems or local procedures and policies. Social workers subsequently set them apart from other administrators, holding some in higher professional esteem than other contemporaries by ascribing increased informal responsibilities. The Latin phrase '*primus inter pares*' (first among equals) springs to mind in this context.

> *'[Name of administrator] had worked for the council for many years and as [name of social worker] said 'she knows [name of IT system] like the back of her hand.' [Name of administrator] created shortcuts on the worker's desktop to make it easier for her to locate forms 'she's been great. There's so many forms.' she kept saying.' (Fieldnote, Site 1, P105, Social Worker, Wednesday, 16/03/2016).*

A lack of available infrastructure, internal guidance and training to newly appointed staff prevented knowledge from being circulated at site one. The formal inability to spread knowledge with staff members resulted in a dearth of what Wenger and Snyder describe as 'communities of practice' (362 p.140). The characteristics of this process facilitates a number of traits; quick problem solving, sharing and spreading best practice, development of professional skills and in helping to retain talented staff (362). These 'go to' administrative staff became key informers of knowledge, sharing experiences with other social workers.

The boundary between social workers and the administrative staff who they work alongside was described by most social workers as being clear and mutually supportive albeit using different skill sets rather than being subservient in the co-ordination and provision of social care. Administrators also defined their role as being supportive to social workers and described clear boundaries between their tasks and those of social

workers. Although, whilst one administrator talked about how she recorded the provision of care, her narrative suggests a sense of being less than equal associates, rather just following instructions:

> *'They [social workers] complete a [name of form] and they [service managers] send out to the external providers, em, asking, em, giving the details, this person needs this service so many times a day. You know, have you got capacity to take it. It's like it going out to tender I think, by the looks of it. We haven't done it, we've just been given instructions….. And then they'll complete one of these [name of form] or do the budget in [name of form] and then put that into us to put on the service package, put on [name of case management system] under that person's name. And then we scan it, and then email it to our financial assessors, they're based at [name of council office].' (Interview, site 2, P201, Administrator, Monday, 04/10/2016).*

Social workers would traditionally email administrators to request client information to be updated on IT systems for example, changes in address, GP or next of kin. Social workers could update client information at any time, although they saw the task as the role of administrators. One administrative manager highlighted the inefficiency of this practice, emphasising that by the time a worker messaged administrative staff with all relevant details, they could have performed the assignment much faster themselves. This particular administrative manager became a negotiator between administrators and social work teams to streamline some working practices. Over the years she had gained knowledge and understanding of the priorities in both departments and could see better ways of working to ease pressure from respective perspectives:

> *'You know, the clerical staff are getting something that's not been completed. Previously they (clerical) would have gone off and tried to fix it themselves and I said* ***No****, that's not your job (emphasis in the original). You know, you can't tell what somebody's done em, you know, any of the work for a case. You need to go back to the worker and the only way they'll get used to filling out the completed paperwork is if you give it back to them to*

do it themselves. So, I've been a bit harsh and been a bit strict. (Interview, site 1, P106, Administrative manager, Tuesday 15/10/2016).

These observations are synonymous with hierarchal behaviour by some social workers where their skill sets were viewed as being more specialised than those who performed what they perceived to be mundane, lower status tasks [254, 255].

9.4.3. Boundary-making by Social Workers towards Other Social workers

The history of social care for older people has shown how the social work organisation has undergone many structural, social, political and economic reforms over the years [18, 20]. Re-organisation resulting from continuous government white papers and initiatives have impacted the focus and role of a social worker [18, 20]. Since the 1980s, social care for older people has shifted from being the largely institutional care of mostly marginalised individuals to caring for much larger numbers of people in local communities using a collaborative, reflective and accountable approach [18, 363]. As such, there has been a shift in formal credentials required in order to continue to perform this complex work. For example, support workers in social care traditionally originated from either a nursing or social care background and did not usually hold any formal qualifications. Some were promoted due to knowledge and experience they had gained over years of practice, performing complex social work duties. However, restructuring of the profession meant the title 'social worker' was reserved for those who had completed a four year social work degree course, based on the new Standards for Social Work Education in Scotland in 2004 [364]. Individuals carrying out complex social work tasks, whether through promotion under previous mandates (nursing or not) or through a social work degree, carried out identical duties and received equal salaries. However, unless an individual held a recognised university degree they could not be called a social worker, introducing some stigma towards those who did not hold degrees. The title 'care manager' was subsequently introduced for those individuals, thus creating a new intra-professional boundary between social workers and care managers. In this study, two of the councils (sites 1 and 3) did not differentiate between these two job titles and identified all social workers as 'care managers' whilst the remaining council (site 2) distinguished between a social worker and a care manager. Staff across all regions

without specific qualifications, but who performed complex work would have to undertake further educational training in order to be considered for advancement:

> *'[Name of social worker] has a nursing qualification and background but has worked with older peoples services in social work for many years. A very experienced practitioner, [name of social worker] was a nurse for the first 6 years of her career and a care manager for over 21 years. [Name of social worker] currently works from [name of locality team] of [name of district council]. She said 'I am a care manager, I cannot call myself a social worker'' (Fieldnote, Site 3, P305, Social Worker, Tuesday, 22/08/2017).*

Social workers operating from a hospital discharge team engaged in different boundary making to those working in the community which were distinctly marked. For example, the therapeutic relationship is fundamental to communication skills and to the principles of social work practice [(365)]. In hospital settings and against the backdrop of tightly prescribed timescales, social workers were not afforded time to develop any meaningful relationship with clients over the course of the assessment and discharge process: *'When you think, you're expected to do an assessment* ***really, really, really*** *quickly (emphasis in the original).' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016)*. Additionally, once clients were released into the community or a care home setting, the original hospital assessor was no longer part of ongoing care. This required different skill sets in contrast to community social workers who were allowed more time and space to nurture rapport and to discover nuanced information (albeit through experiencing different pressures) that may prove important to client care provision:

> *'Information is very important, I tend to not record any information at my first meeting. I feel clients open up more if you are listening to them and not writing things down. I tend to write up my visit on my return to the office. I complete the assessment on another visit so I can go over what is recorded and the person is comfortable with the content.' (Interview, Site 2, P203, Social Worker, Thursday, 06/04/2017).*

As with administrative staff, some social workers emerged as comparable 'go-to' people; considered to hold advanced experience in specific areas of social work which elevated their professional status amongst colleagues. An informal hierarchy in status applied between colleagues of identical formal standing, raising their professional position within their working domain. For example, social work was traditionally divided between specific specialities, for example, learning disabilities, child and adolescents, older people and mental health teams. More recently, these boundaries have become less rigid where social workers now operate across all fields of care. Some social workers subsequently held specialised knowledge in particular areas and these 'go to' people surfaced during the course of the study. Additionally, some social workers had completed a doctorate qualification but who held equal position to those who did not in the social work department. These individuals were often selected to hold workshops and seminars in the community in favour of their contemporaries.

Formal schedules were informally enacted and altered between colleagues to meet the numerous complexities of every day practice which were almost impossible to ascribe in routine procedures. Practice on the ground thus reflected very differently to these official mandates. Additionally, line managers viewed care managers with different levels of trust. Some were afforded a higher level of autonomy whilst others were more closely supervised as the following example shows:

> *'[Name of social worker] and I went through more case notes and I am getting a sense of how the history of a client progresses. I asked [name of social worker] if she sends any of the information she collects to her line manager. She explained that there is one mandatory form that has to go through her manager and that is form TTG1 [Request for funding from council on behalf of client]. Other than that, she uses her discretion in terms of what information her manager needs to know and what she does not. [Name of social worker] also explained that her line manager has access to all her team's case files, therefore she can access whenever she needs to.' (Fieldnote, Site 1, P102, Social Worker, Wednesday 10/02/2016).*

Boundaries between social workers were maintained largely through formal qualifications and local policies. Boundary work was a key way in which colleagues,

negotiated in various ways to allow best use of resources to assist with the high levels of work load encountered in day to day practice. Even straightforward tasks, such as the duty worker rota, were often negotiated and re-negotiated as local formal procedures did not account for such instances that were part of the reality of routine work in practice.

9.4.4. Boundary-blurring by Social Workers towards Health Staff

Whilst social workers engaged in boundary-making towards healthcare staff, significant boundary-blurring also took place. Across all three fieldsites, client care co-ordination and provision were implemented informally to reduce delays in care delivery. Gaps in services, grey areas in policies or procedures opened opportunities for negotiation allowing new but temporary forms of interactions to emerge. In keeping with Strauss's model, negotiation was transitory, each situation requiring a fresh negotiation. For example, nurses would sometimes perform social work tasks as an interim measure until a formal package of care or third sector agencies could be put in place. This temporal process would have to be re-negotiated if a different nurse was brought into the situation or if an extension of the nurse's time was required.

> *'The meeting discussed arrangements for [name of client] personal care, domestic care, meal arrangements and medication prompts. Small adjustments were made to carer visits so that they could attend to fit with his medication timings. The district nurse agreed to cover one of the medication slots as a short-term measure until the care company could fit fully into his schedule.' (Fieldnote, Site 1, P102, Social Worker, Monday, 15/02/2016).*

Arrangements were often off-set through a bargaining approach between health and social care staff where conversations often resulted in mutual agreements to accommodate client care. This gave rise to health staff and social workers to engage in boundary-blurring:

> *'For example, [name of social worker] asked the district nurses if she could fit 3 x visits per week as an interim measure for a palliative care client until [name of charity] could source more care. The district nurse asked [name of social worker] if she could talk to the care providers of another client to remind them to encourage the client to use the commode in her room as it*

was not happening at the moment. Each agreed to the requests in a friendly manner.' (Fieldnote, Site 2, P206, Social Worker, Tuesday 1/04/2017).

In acute settings, health staff would access information systems which were blocked to social care staff in order to assist social workers when planning hospital discharges and care packages:

*'And people are **really** good and will give you the information (emphasis in the original). But if they're not around, then you just base on the information that you've got to hand, which is not great, you know, when you think, you're expected to do an assessment **really, really, really** quickly (emphasis in the original). And there's a whole chunk of information quite often that's held on someone, that you don't have access to.' (Interview, Site 1, P108, Social Services Manager, Monday, 04/04/2016).*

Some policies and procedures exposed fragmentations in joint service planning and delivery. Disjointed policies caused mutual tension and frustration between health and social care workers amidst the backdrop of busy and high pressured working environments. Roles and responsibilities became poorly understood or blurred. As Barrett *et al* and others demonstrated, enhanced clarity of role responsibility was viewed as an important factor to successful multi-agency working [270, 366, 367]. Knowing exactly what is expected and who should perform which duties were deemed crucial during joint working. MDT meetings and co-location helped smooth processes through better communication links bringing a greater understanding of other professional roles. Despite this however, there were incidences where health and social care colleagues were in conflict with one another when executing the needs of clients:

*'There was an additional client discussed who required compression stockings to be put on and taken off daily. Considering the task a medical issue, [name of social worker] asked the district nurse to arrange things. The nurse replied, '**That's not gonna happen'**, i.e. they were not going to provide the service [considering the task social care responsibility] (emphasis in the original). I sensed some tension. Later in the meeting, [name of social worker] casually mentioned she had taken some flexi-time*

yesterday. The same nurse stood at a sideways angle to her and was flicking through a folder. Rolling her eyes and without giving further eye contact to [name of social worker], responded "huh, flexi-time" in a rather sarcastic manner whilst continuing to flick through her file. It was as if to suggest she had an easy time if she could take flexi-time. That was my perception of the situation and it was quite embarrassing. I am convinced if this comment was meant as a friendly exchange of banter, then eye contact would have been made, further remarks of teasing would have continued, and the nurse would have stopped flicking through her folder and engaged more amenably. [Name of social worker] tried to make light of the situation and the awkward silence, responding by joking about all the time she had lost in the past and didn't want to lose more.' (Fieldnote, Site 2, P206, Social Worker, Tuesday, 20/06/2017).

Even where roles and responsibilities were clearly defined, social workers were sometimes frustrated by a lack of impetus and timely response from some health staff when handling Continuing Health Care Assessments (CHCA), an in-depth process to implement complex care requirements:

'[Name of social worker] talked about official procedures carried out by health and social care in order to assess a complex case held by a joint health and social care panel since funding is shared equally. Social work staff are required to complete their outcomes focused assessment [OFA] whilst NHS complete their Decision Support Tool [DST]. Both sets of information are required at the joint panel meeting. [Name of social worker] talked about one particular client of hers who required complex medication requiring specialist nursing staff. She completed her OFA and had to wait 3 months for health to report their DST tool. She chased and chased and felt she wasted an awful lot of time attempting to get the forms in place. She said social work always have to chase these forms. 'No one takes responsibility.' (Fieldnote, Site 3, P309, Social Worker, Tuesday, 26/09/2017).

As Nancarrow and Borthwick and others have reported, successful joint working can result following clarity of roles and responsibilities, especially in terms of who is

expected to perform which tasks and how [270, 366, 367]. However, amidst the complex reality of day to day delivery of health and social care, roles and responsibilities were sometimes unclear and inefficient leading to fragmented or delays in care provision. For instance, as mentioned above local authorities do not allow care staff to administer compression stockings even although it seems to make sense for them to do so, especially if they are already attending to a client's personal care. The policy in its current form meant nursing and social care staff had to attend independently, reducing the efficiency of every day practice. During these instances informal measures were often enacted to ensure care provisions were met. It seemed respective policy documents legitimised boundary creation and maintenance although meeting care in the reality of everyday practice relied upon boundary-blurring to achieve flexibility, efficiency and satisfactory outcomes, often in a mutually altruistic manner, although sometimes reluctantly. Positive relationships amongst health and social care staff coupled with co-location facilitated these aims in many cases.

9.4.5. Boundary-blurring by Social Workers towards Administrative Staff

Some social work and administrative roles and responsibilities changed in an attempt to improve organisational and operational flow in site one. Administrators were given the added responsibility of uploading specific social work client forms to the case management system due to persistent inaccurate recording by social workers, causing tension.

> *'So, we started up em, clerical meetings with the team managers, got them in, basically said, you know, that is all the capacity [administrative] that you've got in your teams. Em, we kind off did a work plan for what the priorities are for the clerical staff and anything below that will just have to wait. But we prioritised things like the, the referrals, the allocations, the closures, to try to keep a flow going of the important things, but anything extra that they wanted done either had to wait or they had to do it themselves.' (Interview, Site 1, P106, Administrative Manager, Tuesday, 15/03/2016).*

The above example shows Strauss's negotiated order and Gieryn's awareness of boundary change in uncertain times with its tug-of-war contest to protect or expand

respective disciplines [262, 271]. Interactions were also synonymous with Witz's model of occupational closure strategies that enable claim to opportunities or resources [355]. For example, on one hand, the administrative manager, protected clerical staff by challenging established social work expectations through re-negotiating perceived low status task requests [262, 271]. On the other hand, administrator responsibilities were increased to improve data recording and accuracy. The administrative manager enacted dual closure tactics following social worker attempts to deploy downward demarcation strategies [355].

The boundaries between social work and administrative staff were always in a state of change. Social workers and administrators within community localities negotiated formal and informal procedures to help accommodate best use of time and resources during every day events:

> *'Each member of the care management team cover as duty manager for ½ a day at a time, once per week. This means that any calls of an urgent nature that come into the older people's services of the social work department are dealt with in a timely manner. The rota is compiled by admin and given to care managers 6 weeks in advance. If care managers cannot fulfil their duty, it is their responsibility to arrange alternative cover. I found out later that due to admin staff reduction of 60%, another care manager volunteered to produce the roster. Colleagues agreed to alter the structure from the previous ½ day commitment to 1 full day at a time to help consolidate slots and to simplify roster production. This volunteer produced the rota in her own time in the evening and worked around colleague holidays, CPD etc as much as possible.' (Fieldnote, site 1, P107, Social Worker, Tuesday, 15/03/2016).*

Administrators frequently checked forms completed by social workers in site two. This was not a formal requirement although through their experiences they regularly found errors on service requests which had to be signed off by service managers. Administrative staff would act as guardians of completed forms and a go-between so that when the service manager received the request, information was recorded as it

needed to be. The administrator's response is highlighted in bold to differentiate from the researcher:

> *'R. How many times would you say you check information? Like you think, oh this doesn't look right, or that doesn't look right.*
> ***P201. Every day I think, eh [name of administrator].'***
> ***P202. Laughs**.*
> ***P201. Sometimes especially with them (gesturing towards social workers' office). Oh God, I put it back, and then they tweak it, and then we'd get it back and then something's changed or…. But certain packages go on [name of form]. And the community meals and the community alarm, and laundry, they're, and preventative support go on that, [name of another form]. (Interview, site 2, P201, Administrator, Monday 04/10/2016).***

Within the harsh reality and complex world of day to day health and social care, the boundaries between administrators and social care staff resulted in constant negotiation and re-negotiation of duties. They performed tasks that were not included in ordinary procedures and which crossed professional boundaries in order to maximise efficient and more streamlined ways of working. Staff shortages, increased burden of work load and severe financial constraints added to the complexities of meeting care, causing tension at the boundary between social workers and the administrative staff whom they worked alongside.

9.4.6. Boundary-blurring by Social Workers towards Other Social Workers

Informal discussions and sharing of tacit knowledge between social workers lead to mutual understandings, introducing boundary-blurring. For example, all local authorities provided an inventory of nursing and care homes that were commissioned to accept council funded clients. However, some care establishments were deemed troublesome whilst others were viewed more co-operative and flexible and this knowledge was communicated to other co-workers resulting in a reluctance to recommend admission to specific residential settings. In Strauss's work, he noted how some nurses would become 'guardians' of hospital rules to dispute some psychiatrist demands [262 p.152]. Social workers acted as guardians of their clients in a similar manner by rejecting council

endorsements of some care facilities. Boundary-making was facilitated by the official presence of certified council funded establishments although boundaries became blurred through informal consensus and actions between social workers.

Social workers would often take ownership of particular tasks, despite there being no prerequisite to do so.

> *'I noticed that one wall was covered with brightly colour-coded laminated information notices of available services with useful contact information. Each notice was A5 in size. (Name of social worker) told me she had created these and kept them updated so that new or inexperienced staff in adult services or learning disabilities could see what resources were available in the local area. It reminded me of what (name of social work manager) had told me about newly trained or recently appointed social workers and how they may not have knowledge of local area services, likely impacting the type of care package arranged. This was a primitive but very effective way of sharing information, thus minimizing inappropriate or ineffective provisions. (Fieldnote, Site 3, P309, Participant No 309, Tuesday, 26/09/2017).*

All social workers are obliged to maintain continual professional development (CPD) training, sometimes referred to as post registration training and learning (PRTL), or organisational and professional development (OPD). CPD is intended to improve work practice, career progression and contribute to life-long learning [368]. Guidelines are purposively generic given the acknowledgement that different practitioners will required different types of learning [368, 369]. Presently, social workers are required to carry out 15 days (90 hours) of CPD every 3 years or 24 days (144 hours) for newly qualified social workers in their first year. Social workers under study were each given the responsibility to keep abreast of their own CPD schedules and activities. These were viewed as informal rather than clearly structured protocols in localities, and did not have to be endorsed by line managers. Staff tailored programmes to fit with case load requirements, although some staff were unable to conform as diligently as others:

> *''I met up with [name of social worker] later and asked how she managed her CPD training amidst her caseload. She said she did CPD when she could but this was proving more and more difficult. She explained that the onus lies with the worker to book training but she felt guilty and stressed at leaving her cases that needed attending to. She was always behind with training. I learned she would like to study more but she emphasised she was already mentally exhausted and didn't feel she had the energy, head space or time. Also, she said she needed to keep what energy she had for her clients and admitted she had a fear of missing something because of service pressures. (Fieldnote, Site 2, P206, Social Worker, Thursday, 22/06/2017).*

Boundary differences between co-workers of equal standing emerged during the study. Some social workers and administrators evolved as informal connoisseurs in specific areas of social work to which others sought in times of uncertainties during everyday tasks. These staff were also afforded more autonomy by line managers relative to others of equal formal standing. There was a tendency for some staff members to abandon or significantly delay CPD in favour of focusing on the pressures of client care and case load numbers creating boundaries of a different form between social workers.

9.5. Summary

Different elements of professional attributes (power, professional identity, boundary work) influenced how health and social care information was collected and managed, ultimately shaping client care pathways. This chapter has shown how each profession supported and defended a different ethos, set of values and practices which impacted data processes and client care decision-making during joint working. Sometimes positively, but often to the detriment of social care beliefs meaning most social workers operating at the front line felt their decisions and recommendations were often disregarded in contrast to more powerful health care staff. Observations and interviews illustrated health and social care staff of high and low standing were under increased work pressure largely due to austerity measures, but sometimes through inefficient ways of working.

In agreement with the literature, professional dominance by healthcare staff was apparent particularly in hospital settings where social work staff formed a marginalized

section, limiting their power. However, social work staff were emboldened to challenge clinical care path decisions and in some cases were successful. Where they were not, it was normally by clients who saw healthcare staff as the specialists in their care need or by clinicians who were understandably risk averse given current organisational and operational directives. In community settings, professional dominance was not as obvious where 'collegial facilitation' rather than an authoritative approach took place during MDT meetings or case conferences [348 p.901]. However, incidences of differences in professional identity including different practice styles and beliefs impacted decision-making during joint care planning processes. Social workers felt undermined and undervalued as client care pathways often conflicted with healthcare views and were considered detrimental to social care principles. Professional dominance was exercised by social workers when working alongside administrative staff. Some social workers viewed their skills more highly than those of clerical workers, impacting work patterns and professional relationships. Positive relationships between social workers, healthcare staff and administrators which developed over time helped to mitigate many professional power and identity situations.

Boundary-making and blurring assisted and inhibited operational demands in equal measure. Boundary-making was initially enabled through formal qualifications and mandatory registration, reinforced through local policies and procedures. These were conveyed to health and administrative staff via electronic or verbal means during MDT meetings, case conferences or routine practice. Social workers used formal policies to validate and inform the scope of social work roles and responsibilities. As such, social work statements were frequently incongruent to aims and objectives of healthcare principles and priorities causing strains between the two. Boundary-blurring work by social workers operating alongside health and administrative staff occurred generally due to a lack of clear procedures, a lack of acceptable infrastructure and inadequate resources to accommodate the messiness in everyday events. Social workers constantly negotiated and renegotiated tasks. Good joint working relationships and approval from insider professionals helped outsider social workers earn recognition as an insider, aiding speedy resolutions to quandaries. On the other hand, unfamiliarity of other professional roles, operating from a distance, alongside increased work-loads in all areas of health and social care caused tension. The consequences of which led to the protection of respective work practices and professional stance, hampering smooth working. It

seems professional boundaries are required to be both explicit and flexible, in so far as everyone needs to know what they are expected to do whilst at the same allow flexibility to adjust for the unexpected.

This chapter has illustrated the presence of power and professional identity through the examples provided. The chapter also exemplified boundary-making and boundary-blurring in every day work experiences of health and social work staff. Each component of power, professional identity and boundary work influenced social care data management, care decisions and client pathways, ultimately impacting clients, their families and carers. The next chapter brings the analysis chapters together and discusses common concepts of interrelatedness across the study themes. Some theoretical and pragmatic applications are offered to address opportunities and challenges of this complex mix. Client data and care pathways could improve leading to a more cohesive health and social care integration strategy for every day practice.

10. CHAPTER 10. DISCUSSION

10.1. Introduction

This thesis is one of the first studies to evaluate routinely collected social care data processes in UK - from origins to output. As such, and from the ground upwards, this study examined how social care data materialised in the first instance; exploring information gathering processes, client assessment procedures, coding and decision-making practises. The study also investigated how data were used, shared and managed between social care agencies and also how data flowed across health and social care sectors. Factors that assisted or hindered the smooth running of a client's care journey were identified from social care and also health and social care integration perspectives. Findings bring an in-depth understanding of data flow and practices in order to provide health and social care staff, data analysts, as well as the wider research community an awareness of strengths and weaknesses of entire data pathways. This knowledge will greatly assist anyone collecting, recording or using social care information either in isolation, through linking social care data with health information, or through combining with any other data sources. Given the considerable wealth of articles in the literature that have evaluated health care information, in contrast to a lack of social care data appraisals, this study also addressed disparities in knowledge and understanding between the two organisations.

This chapter begins with a review of the four overarching themes from the results chapters which provide an in-depth description of social care data processes from multiple approaches (semi-structured interviews, observations, supporting documents) and viewpoints (executives, managers and front-line social work staff). Key concepts of influence highlighted from these findings contribute to a new body of research. This chapter then answers each of the research questions in turn. At this point, it may be appropriate to reiterate these once more:

1. What factors affect the collection and management of social care data in integrated services for older adults?

2. How are professional boundaries negotiated between social care and health staff in integrated care settings as they collect and manage data?

3. What is the value of ANT for exploring data in practice?

4. How might data collection processes be improved in integrated care settings?

The first research question is answered by discussing three specific attributes which cross-cut all of the main themes and sub themes and in doing so provides an overarching approach to viewing the findings of this study. The three factors identified (standardisation, philosophies, leadership/management) will be introduced prior to describing their impact on client data and care journeys. The chapter then considers research question two with a discussion around how social care and health staff negotiate professional boundaries. The next section considers research question three in terms of examining the value afforded to the project by adopting ANT theoretical framework for the study, highlighting strengths and weaknesses throughout. The final section answers the fourth research question, outlining areas where data collection and management could be improved in social care and also in health and social care integrated settings. The chapter closes with some recommendations for future work.

10.2. Review of Themes

The concept of health and social care integration seeks to streamline systems and services within the health and social care landscape and to maximise experiences and outcomes for clients/patients, their carers and families [100-102]. Themes from analysis that were important to understanding social care data processes and for health and social care integration to prove successful are shown in Figure 9. The diagram illustrates the four main themes that emerged during analysis alongside their sub-themes. Topics are compartmentalised beside each main theme, although some overlapping concepts were identified. For example, collaboration was a topic that was raised a number of times during the study from a data processes point of view, but was also highlighted from an IT systems, organisational, and intra/inter-professional relations perspective. The

schema provides a varied and comprehensive account of issues described, enacted and witnessed throughout interviews, observations and supporting documents. These wide-ranging issues show the complex and diverse permutations of topics expressed by social care staff on a day-to-day basis. Social care data processes and management are therefore, neither simple nor homogeneous.

From a policy perspective and throughout the literature, integration is often times spoken about in terms of fragmentation [370-372]. Figure 9 considers a less pessimistic view in that the diagram presents topics that this study found to encapsulate successful integration, albeit the subsequent narrative still recognises challenges and opportunities across themes. Hudson noted these as matters of commonality and compatibility (optimistic) versus distinctiveness and differentiation (pessimistic) views of integration [373]. These four themes are summarised as follows:

Theme 1. Data Processes

Entire data collection processes were represented in the analysis section where factors that impacted data procedures were identified by social work staff at executive, managerial and administrative level of operations. Views from observed front line staff were also depicted offering a holistic approach to data pathways. Routine procedures and practices during a social work referral, assessment of need, care provision and ongoing data gathering in older people resulted in a wealth of described experiences, expressed as successful practices as well as exposing some issues of concern. Different origins and channels to which referrals travelled were presented incorporating the numerous agencies involved in order to meet client care. Variance in staff practice styles, work-flow patterns, language and terminology between and across agencies illustrated the complex and real world of delivering health and social care at this grass roots level. This theme illustrated the diversity in topics raised from this perspective that shaped day to day practice.

Theme 2. Information Technology Systems

This theme highlighted how information technology and electronic devices proved integral to data processes in health and social care organisations. Different topics that emerged brought a deeper understanding of the issues that affected data collecting,

coding and managing of these data sets in an attempt to streamline service recording and intra/inter-organisational access to and sharing of information. Many examples were provided to demonstrate how IT assisted and hindered in these aims. Current developments that are underway will help to continue to take full advantage of the potential to use these data sets to evaluate service access, use, and also in determining future planning.

Theme 3. Organisational Systems

Not surprisingly, organisational systems enable data processes and IT systems to function through the considerable infrastructure that accompanies complex enterprises such as health and social care. This theme highlighted aspects that facilitated and hampered these very developments. For example, organisational systems are responsible for implementing policy mandates, encompassing routine procedures and terms and conditions of employment. The organisational system also provides the professional environment and resources to fulfill the very obligations of health and social care, without which would undoubtedly result in disarray and inconceivable outcomes for staff, notwithstanding clients, their carers and families.

Theme 4. Inter/Intra-professional Relationships

Inter/intra-professional relationships emerged as a key theme in the delivery of health and social care. Many topics were articulated by health and social care staff in terms of what encompassed successful integration. A combination of factors portrayed experiences including matters of ideology, co-location, rapport, inter-disciplinary joint working, team roles and responsibilities which embody the wide-ranging encounters realized in everyday events.

When considering findings from all these themes, the whole is certainly more than the sum of its parts. Data processes, IT systems, organisational systems and inter/intra-professional relationships do not correspond to a universal process, but rather they are a fluid mix of innumerable and contextual, inter-related permutations. For example, data collection processes were heavily dependent upon reliable and flexible IT systems. Organisational systems such as policy directives, availability of resources and services, were essential in providing the legal, moral, and practical foundations to accomplish integrated health and social care. Inter/intra-professional relationships influenced how

such policies were interpreted and implemented creating a cycle of ever-changing combination of factors.

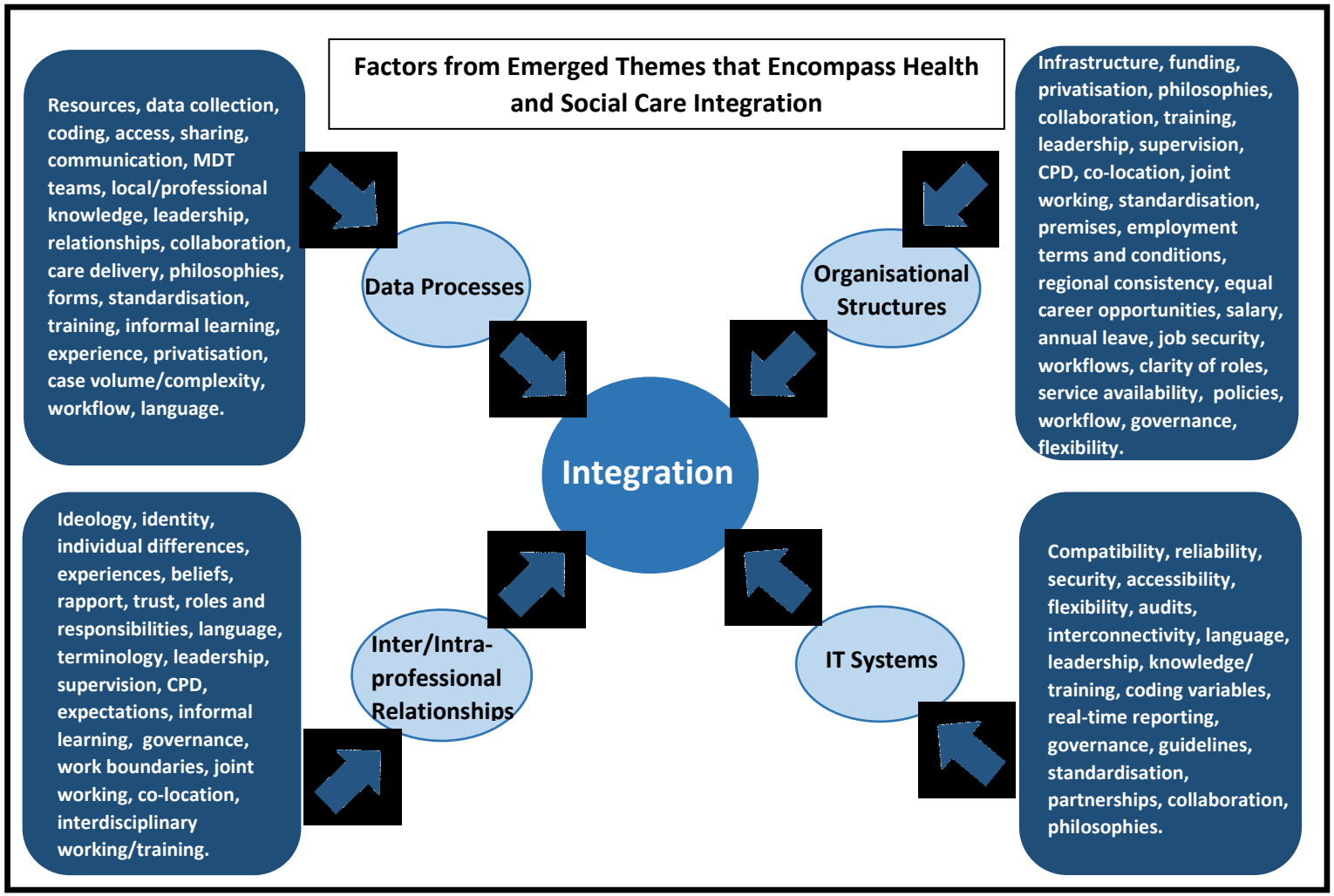


Figure 9. Factors from main themes and respective sub-themes that encompass health and social care integration.

10.3. Standardisation, Philosophies and Leadership/Management

Having consolidated themes in Figure 9, and then having revisited, reviewed and reflected across the four main themes and sub-themes, it became apparent that three predominant attributes were significant factors that affected the collection and management of social care data in integrated services for older adults; standardisation, philosophies and leadership/management (Figure 10). For instance, the outcome of each situation or event articulated during interviews or witnessed during observation periods was contingent on how each of these three attributes were enacted. This section now describes these attributes, then discusses their inter-relation with the findings from the results chapters as an overarching approach of viewing findings from this study. These concepts help to answer research question one.

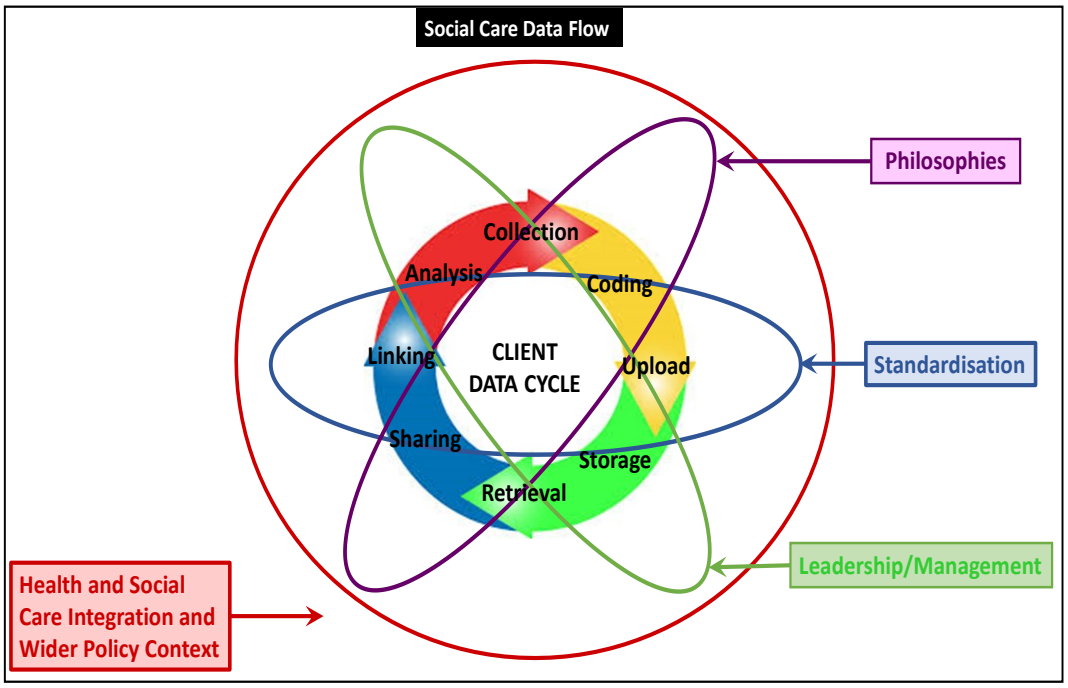


Figure 10. Social Care data flow incorporating standardisation, philosophies and leadership/ management in the wider policy context of health and social care integration.

10.3.1. Standardisation Overview

Standardisation can be viewed as mechanisms to maximise formal processes through creating and implementing standards within fields of law, medicine, business, governments as well as other organisations [374, 375]. For example, in the context of this study, government agencies, NHS partnership organisations and local authorities

develop statutory documents and guidelines which authorise and support social care services and health and social care integration strategies [15, 106, 186, 376]. Consequently, social care policy and practice rely on a variety of knowledge sources in order to help practitioners, policymakers and analysts in ways of collecting information and in assessing the quality of data gained from these knowledge sources [377]. One of the most commanding and comprehensive attempts to identify and apply standards in research and practice can be found in the report from the United States Joint Committee on Standards for Educational Evaluation [378]. Here, the publication proposes thirty standards that fall into four quality knowledge assessment categories: utility, feasibility, propriety and accuracy. In the UK, there are many tools to aid the appraisal of information and knowledge quality. The UK Social Care Institute for Excellence (SCIE) commissioned a review to consider what knowledge social care should draw from so that the evidence base is formed from different sources of good quality information [379]. Following the review, Pawson and colleagues conclude with five sources of knowledge; organisations (governance and regulation), practitioner (experiential and tacit), user (service users and families), research (empirical enquiry), policy community (wider policy context), [379 p.25-26]. It is recommended that each knowledge source be assessed using the subsequently developed framework which was afforded the acronym TAPUPAS to reflect the seven properties that should be tested to meet knowledge quality (Table 8).

Table 8. Framework of generic standards to test social care knowledge [379 p.37-40].

Property	Question
Transparency	Is it open to scrutiny?
Accuracy	Is it well grounded?
Purposivity	Is it fit for purpose?
Utility	Is it fit for use?
Propriety	Is it legal and ethical?
Accessibility	Can you understand it?
Specificity	Does it meet source-specific standards?

In view of the fact that these generic standards were developed to test social care knowledge through the formation of a critical appraising process, they were then tested in a small-scale evaluation and found to add value, although like most tools some

limitations were noted [377] . The framework was found to be a practical approach to assess the quality of documents and practices across all areas of knowledge sources. Its common set of standards were applicable across health and education as well as social care knowledge. Limitations included concerns around distinctiveness and interpretation where the framework may be inadequate for systematic reviews or randomised controlled trials (RCTs). Acknowledging flaws, SCIE recommend the use of the Critical Appraisal Skills Programme (CASP) tools to address such failings [380]. In today's world of evidenced based policy and practice, it is right and proper to question such data quality. For this study, the TAPUPAS framework was a fitting place to begin.

10.3.2. Standardisation in Practice

Throughout the study, integrated services were well established incorporating joint initiatives with social workers, consultants, GPs, district nurses, AHPs, OTs, physiotherapists, pharmacists and other health, social care staff. A range of collaborative services were in place across all regions which focused on prevention strategies such as Step-up-Care, Rapid Response teams, Enhanced Community Support, Early Intervention teams and Respite to avoid unplanned admissions to acute hospitals. Immediate Discharge Service (also called Early Supported Discharge) was an additional initiative, introduced to reduce hospital delayed discharges. Community care departments managed a wide variety of joint service provisions that supported diverse client need to enable users to live in their own homes as independently and for as long as possible. These ranged from complex care packages requiring contributions from numerous disciplines to more straightforward cases involving just one or two partnership agencies. MDT meetings on hospital wards and in community settings further supported the co-ordination and provision of joint collaboration in health and social care in a routine and pragmatic manner.

Information processes assisted with the provision of services smoothly and speedily much of the time. However, a lack of standardisation in forms and poor workflow design led to delays in care assessment, decision making and planning alongside a great deal of duplication effort. This was prominent in both hospital wards and community settings, although it is important to point out some regions were more developed than others. Standardisation of forms at this level typically promote procedures to enable routine collection of client information in order to enable equal access, provision, co-ordination

and analysis of services. Standardisation has many advantages in that consistent and uniformed ways of gathering data can be facilitated whilst also reducing duplication effort. On the other hand, the introduction of standardised approaches risks the loss of uniqueness and richness of individualised information. A balance is therefore essential in order to achieve uniformity in data collection processes to enable ways of providing and analysing service access, use and delivery. However, there is also a great need to retain the distinctiveness of individuality to facilitate the core principles of person-centred care.

Gathering client information was hampered in many cases from both a standardisation and richness perspective, interrelated with leadership/management and philosophical beliefs [374]. For example, when clients were referred to social work through the hospital discharge system, ward staff completed different versions of a referral form to that of social work. Different terminology, language, and wide variations in the range of data collected made transfer of information inconsistent and inefficient and breached the TAPUPAS framework in terms of being fit for purpose or use. Fragmented methods during delivery of a referral to social work departments coupled with isolated IT systems exacerbated what seemed disjointed processes at this grass root level of care pathway. Additionally, inconsistencies in inter-disciplinary policies and procedures impacted recording patterns and led to a profusion of duplicate information gathering. Similarly, some information was held in text form whether codes were already assigned or not, meaning that potentially important information was hidden in case notes. Tracing this information for analysis or audit proved challenging and this occurred across all departments and regions. Case note information in general was difficult to utilise from an analytical perspective. A lack of expertise to perform discourse analysis (or comparable framework) in local authority departments limited their usefulness. There was just one occasion during the entire project where case notes were used to calculate social work staffing levels. The use of pseudo variables were applied successfully in a branch that was particularly well developed with supporting analytical expertise. This last point is particularly interesting since further development of case note analysis could prove fruitful especially given these documents play a central role in all decisions around clients and client care.

Standardisation (or a lack thereof) was aired in other forms for instance, in relation to joint working teams where staff who performed identical roles and responsibilities were subject to different terms and conditions of employment which were viewed as unfair and potentially discriminatory. This included inequalities in salaries from a pro-rata/scale alignment perspective to annual leave, opportunities for career advancement and job security. Joint working initiatives were at risk of being undermined through exposure to contentious and divisive directives. For example, line managers (health employed) overseeing local authority staff were unable to view personal records of people under their charge. Therefore, managing teams to mitigate situations such as sick leave or long-term absence could prove problematic. Questions were understandably raised in terms of how organisations could operate integrated teams when clear imbalances dominated, reducing the potential for health and social care integration to prove successful. This was of course contingent on which association one held with which organisation. Health and social work staff expressed different but mutually arguable disparities. For example, when applying for integrated positions, health staff feared they may be viewed less positively for advancement since any reductions or changes in organisational strategy would work against their non-redundancy employment policy. Conversely, local authority staff matching into integrated positions were faced with different fitting criteria compared to that of health candidates. Favourable outcomes tilted towards health staff applicants making an unequal playing field for advancement. Other disparities exacerbated inequalities between health and social care staff such as hot desk provision which was a bone of contention during joint working ventures. Social care staff working from the same location as health colleagues did not have allocated desk space contrary to their health partners whose work space was dedicated and funded independently by NHS.

Standardisation in relation to government and partnership organisational strategies and regulations to authorise health boards and local authorities to develop integrated models of health and social care data sets were evident throughout the project. These high level sanctions however, did not always translate to successful health and social care integration analysis. For example, at the beginning of the project and during some of the first interviews, numerous accounts were offered to describe how difficult it was to establish what data were available, where to find these data and who to contact to request

these data sets. Rapid progress ensued as the project developed where channels of data sources became more accessible.

Health and social care partnership organisations in Scotland are encouraged to align their strategies and policies to local circumstances and populations. Data sharing protocols were firmly in place, yet despite permissions, there was a reluctance for some data controllers to share data sets. Fear of repercussions under different profession-specific governance were expressed alongside concerns with General Data Protection Regulations (GDPR) suggesting protocols were not sufficiently clear in their mandate. And if they were, this information did not filter through to data managers resulting in a lack of confidence to share information out with their own area of employment, discipline or region. As noted by Miller and Freeman, joint working can be hampered by the impact of management policies when translated to day-to-day realities of routine operations [381]. Additionally, ill-defined roles and responsibilities alongside contrasting organisational priorities in data or IT systems development detracted from joint working and led to further confusion and an unwillingness to collaborate in this context.

Analysis of specific data had the potential to produce constrained findings through a lack of form completion, lack of professional understanding, or lack of standardisation in information requests. Standardisation which offers a framework in which to measure performance through small and large-scale analysis of service access, quality and use was variable from this perspective. Despite weaknesses in data gathering and coding however, highly motivated leaders and managers proactively scanned data-sets for irregularities and omitted information. Data anomalies were fed back to teams on a regular basis in a concerted effort to improve data quality and consistency. These checks greatly assisted data managers to submit more accurate core indicators to the Scottish government in their quarterly returns.

10.3.3. Philosophies Overview

Philosophical stances are concepts where people associate with attitudes, values and beliefs of a specific school of thought or professional group. Individuals of different philosophical viewpoints compare and differentiate their personal and professional stance from other groups [273]. From a health and social care perspective, professionals are to a large extent a product of their historical legacies; different identities, different

status, different education systems, different skills, different management structures and different accountability, each holding different aims and objectives [382]. How these factors inter-relate between and within professional groups will often shape diverse patterns of group behaviour [383]. As Mary Sullivan suggests, 'the course by which professional ideology matures and then directs practice would appear both complex and multifaceted' [384 p.1306].

The introduction of health and social care integration presents opportunity and need for collaborative inter-professional working; different professionals working together in a common pursuit from strategic, executive, operational and technical interactions. Integration is considered to offer greater benefits to both client outcomes and organisational structures [385, 386]. However, an emphasis on inter-professional collaboration has given prominence to professional differences where viewpoints or allegiance to respective ideologies can impact joint working initiatives, care decisions and client pathways. Hudson noted three areas where professional rivalry can play out; 'professional identity, status and power of professions, professional discretion/accountability' [350 p.8-10]. He confirmed the durability of the 'pessimistic model' of inter-professional working whilst also shedding light on the potential for a more optimistic view of health and social care inter-professional collaboration [350 p.15]. In a later publication he further distinguishes the 'pessimistic' (distinctiveness and differentiation)' from the 'optimistic (commonality and compatibility)' models concluding that the capacity for successful professional integration is much greater than previously anticipated and that the pessimistic view may have been somewhat overstressed [373 p.5-6].

Other authors note different points of reference, for example, in a study examining stereotypical attitudes and beliefs of first year undergraduates from ten health and social care professions (n=1200), each were asked to rate perceived skills of other health groups [387]. Statistical significance was found with social workers, midwifes and nurses as they scored highest in interpersonal skills and in being team players. On the other hand, social workers were rated lowest in holding practical skills than all nine other health and social care groups listed. Doctors were rated significantly higher in decision making. These established and consistent perceptions were expected to develop as the professional socialisation process ensued during and following training in respective

domains, potentially impacting future career practice and behaviour. In a further study, nurses and social workers operating joint working ventures valued the benefits integration brought [386]. Nurses reported a greater understanding of social care functioning when co-located in a social services environment, describing a positive impact of working in a different setting. They also experienced gaps in social care eligibility criteria versus what they viewed as care need, causing frustration. This required a delicate balance of making shared concessions over different professional benchmarks to care provision. Other research supports the value of joint working with social workers placing a clear emphasis on the benefits of joint training opportunities [367].

The literature reports successful partnership working particularly where professionals held a default position of mutual respect, effective communication, followed by well-defined strategic priorities, shared objectives, as opposed to generalised uni-professional goals [382]. Conversely, failures in collaboration could result in the absence of any or all of the above characteristics. For example, breakdown in communications could originate from what might seem benign information at the outset; not taking note of a discussion or failing to convey or share a change of diagnosis, only for a crisis to occur as a result. Meads and colleagues write extensively around the subject and claim 'whilst the benefits of collaboration are numerous, the dangers of non-collaboration can be grave' [331 p.153]. Whilst agreeing with this point, and having witnessed a willingness from both health and social care sectors to collaborate, organisations need to have the supporting infrastructure in place to facilitate this. It is also worth mentioning that in theory this might seem very simple and obvious, but is more complex in practice. Without appropriate underpinnings, collaboration in practice would be fraught with problems particularly considering the noted disparities between health and social care philosophical stances.

10.3.4. Philosophies in Practice

It is worth reflecting over the previous section on standardisation and consider that even in an ideal world, (if one could imagine) where referrals, assessment forms and methods of delivery were standardised and IT systems were inter-connected, conflicting opinions portrayed in this study confirmed other compounding factors that influenced what information was collected, within and across professional domains. For instance,

different schools of personal and professional philosophies impacted how individuals and organisational groups functioned [273]. During multi-disciplinary team settings, it became clear that different ideologies, principles and values shaped what data were collected. Some information processes were performed smoothly and speedily whilst other approaches became a source of opposition embroiled around inter-professional beliefs and practices as follows:

Information gathered was largely at the discretion of the assessor and dependant on what was viewed as pertinent or important information to include, conditional to their personal/professional stance. Numerous examples of different views were expressed as to why some information was omitted despite being a prerequisite. There were instances where social work staff were reluctant to collect core indicators such as ethnicity, religion or nationality, mostly originating from and reflecting personal and professional beliefs. In the same vein, health staff on wards offered scant patient information during the referral process. Inconsistent information collection in this context risked timely care provision, a denial of the client's whole health and social care experience, and diluted person-centred care principles. A lack of key information also restricted analysis. For example, a recent report by the Scottish government reported 59,270 individuals receiving social care services across Scotland did not have ethnicity details recorded against their client record [388]. Additionally, and based on 37,120 Home Care clients aged 18+, there were 22,520 cases where data relating to living arrangements (i.e. living alone) were not recorded [388].

The type, volume and accuracy of information gathered was also contingent on how an assessor understood questions from forms. Some staff lacked knowledge and understanding regarding what information was required as some questions were ambiguous and lacked meaning. Additionally, others did not appreciate the importance of data collection, rather they viewed the task as a mundane tick-box exercise detracting attention and time from their clients/patients. That said, there is an important point to bring to light in terms of the inevitable trade-off between the amount and type of information collected versus the urgency to deliver a referral, particularly in acute settings. Nursing staff already working in busy and demanding environments, saw the delivery of a referral as the priority and patient information less important, regarding the latter as the responsibility of the social worker to gather. Conversely, social workers felt

a lack of information delayed the entire referral process as well as produce a great deal of duplication effort particularly given isolated IT systems; adding to the burden of tightly prescribed timescales. Both points of view hold merit, although local forms and disjointed procedures intensified respective frustrations. If professionals within and across disciplines at managerial level cannot agree a unified criteria at this basic building block of data gathering, developing processes further along the care pathway may prove futile.

Different philosophical views caused disagreements between health and social work staff when client care pathways were being decided. For example, in acute settings, clinical advice was often in contrast to that of social work proposals causing confusion and anxiety for clients, carers and their families. Clinical views circumscribed social work plans, driven by more powerful health sector priorities and philosophies, and where social work practitioners were often forced to justify their care plan decisions. Strongly held and contrasting professional identities strengthened an in-group/out-group culture even during joint working ventures. Many social workers believed they were regarded subservient to healthcare staff particularly when small teams operated from much larger and more powerful NHS settings. Social care assessment findings were often criticised, challenged or overruled by GPs, consultants or nursing staff. Additionally, patients would often accept advice from healthcare staff than social workers putting case workers in arduous positions. Many examples illustrated professional dominance; supported by both healthcare staff and clients. For example, GP, clinical and nursing recommendations often conflicted with social care's strict eligibility criteria. Therefore, clients were not entitled to local authority funding, making social work decisions seem somewhat harsh and villainous. Additionally, community district nurses would advise care pathways which clashed with local authority policies where social work principles of managing risk factors and empowering self-managing were undermined. Care pathways did not necessarily reflect care need in some cases but rather an averseness to risk management, inappropriate use of available services or lack of available resources. The latter two factors were highlighted by Lynne Wrennall who claimed social workers were 'expected to wage a lone battle against powerful economic, legal, organisational and bureaucratic obstacles.' [(116 p 176)]. Acknowledging these pragmatic realities impede social workers in their ethical and legal obligations. Wrennall strongly urged that these factors be 'recognised, analysed and confronted' [(116 p 176)].

Power imbalances were not confined to health and social care staff. Traditionally, social workers were regarded as being overindulged with support from administrative staff who would perform what was considered mundane or lower status tasks. The example of one social work manager who emptied his entire team's case note cabinet on to the floor then summoned an administrator to put them back in alphabetical order illustrates this sense of perceived superiority. The onset of austerity meant a reduction in administrative staff and an increased necessity for social workers to perform more and more clerical tasks, causing tensions. Power imbalances were often ameliorated through good inter and intra-professional relationships and also through some administrators earning higher status and respect over time through the process of 'earning one's stripes' [349 p.573].

These findings might help to partially explain the gulf in public opinion between the two organisations as noted in section 2.6. [p.25-26]. MDT meetings and co-location policies fostered better inter-professional relationships and a greater understanding of different professional roles creating a more inclusive working environment. In agreement with Glendenning's report, staff were also able to gain a mutual understanding of different organisational, financial and accountability frameworks from which they operated [389]. Never-the-less, from social workers' experiences witnessed during observations and captured in interviews, there is further work needed to address professional dominance.

10.3.5. Leadership/Management Overview

Leadership and management can take different forms and have been defined through a variety of theories, all of which have modelled different representations [390-392]. What is widely recognised is that in order to be a leader or manager one has to have members. Leadership and management can co-exist at all levels within organisations and are often inter-related although differences have been identified [393]. Practice styles and competencies will vary at every level however, common features are to provide individual and collective guidance, direction and motivation in order to achieve organisational aims and objectives in a context specific manner [392]. Leadership and management have been recognised by governments, the NHS and social care organisations as critical factors in health and social care services resulting in a plethora of leadership development programmes and leadership competency framework publications since 1980s [394].

The development of health and social care integration calls for leaders and managers to take responsibility for different professions and roles which bring additional challenges than those typically experienced in single organisations [395]. For example, Reeves and colleagues note difficulties in joint working health and social care teams which functioned through exclusive education and individual professional socialisation, restricting shared language and purpose in joint ventures [396]. Additionally, different professional responsibilities and line management structures created a demanding and complex team leader/management environment. Further limitations were acknowledged from respective professional histories where staff competed for professional control, generally through medical dominance. Conversely, a more recent review by Smith and colleagues identified factors and characteristics of successful collaborative, collective and shared leadership in inter-professional health and social care teams that delivered higher performance and greater service user outcomes [394].

For the purpose of this study, leadership/management is defined as behaviour or qualities that are exhibited by service managers or team leaders who oversee front line staff or integrated teams. For example, characteristics synonymous with good leadership/management such as guidance, motivation, mentorship and level of engagement are examined alongside the manner in which these qualities are manifested by staff in routine practice. Additionally, the manner in which service managers and team leaders interact between and across different agencies will also be explored to offer a holistic interpretation of collaborative skills and development capabilities.

10.3.6. Leadership/Management in Practice

Having explained the concepts of standardisation and philosophies, and the reality in practice, it then became clear that leadership and management played a crucial role during routine operations particularly when employing and coordinating resources. This study found that strong leadership and effective management resulted from a clear vision of objectives and dedicated inter-professional rapport which improved service co-ordination and delivery particularly where disconnects and divisions in formal policies and procedures occurred. For example, leaders and team managers who forged strong relationships with external care providers and inter-disciplinary teams were able to maintain service continuity to existing service users. New clients were matched into

temporary or long-term care packages more quickly, effectively and creatively despite challenging times and limited resources. For instance, when services required adjustment, but then breakdowns in other lines of communication occurred, managers were able to rely on mutually nurtured relationships to restore service continuity. Additionally, inclement weather brought many challenges when caring for clients living in remote regions. Through creative collaborative initiatives client welfare was maintained in rural outlands.

Team members often emulated their team leaders' stance, incorporating pragmatic workarounds to ensure service consistency when faced with poor workflow design, organisational and/or professional barriers. For example, health colleagues working alongside local authority staff in hospital discharge teams would access electronic information blocked to social work staff in order to assist during client assessment and care planning. Additionally, district nurses, care managers and external providers would hold informal discussions and agree ad hoc ways of working to meet client need when service availability was temporarily compromised or when adjustments were required. Moreover, those leaders who assumed mentorship duties and who were more engaged with their staff were more likely to generate more cohesive teams where members often followed and matched positive and progressive practice styles and behaviours. They formed relationships with other professionals based on shared rather than opposing values making joint ventures possible and more liable to succeed. This was noticeable during decision making processes following client assessments. Information gathered incorporated a multitude of factors based upon an understanding of individual client circumstances and knowledge gathered from several sources with many intricate layers. Team leaders who were highly driven and who operated a cohesive team approach were influential in assisting social workers when evaluating complex or sensitive areas of client concern.

Inter-disciplinary teams who established reciprocal rapport and trust were also at the heart of the evaluating process, achieving the government's aspiration of a whole system approach in many cases [23]. Co-location encouraged formal and informal network building alongside a greater mutual understanding of multi-disciplinary roles which assisted enormously in joint ventures. Despite some excellent examples of joint working, some commented on a lack of alignment and clarity in organisational structure leading

to confusion over how to communicate failures during crisis periods and who was responsible for doing this. A refusal to accept responsibility seemed to ensue causing difficulties when attempting to disentangle problems during breakdown in IT systems and organisational structures with a seemingly 'pass the buck' outlook.

Boundary-blurring resulted principally from unclear and poorly understood roles and responsibilities of different professionals leading to fragmented or delayed care. Innumerable permutations of contextual situations occurred exemplifying the complex reality of day to day planning and delivery of health and social care services. It seemed respective policy documents and procedures legitimised boundary-making although meeting care in everyday practice relied upon boundary-blurring to achieve flexibility and satisfactory outcomes. Positive inter and intra-professional relationships coupled with co-location and MDT meetings assisted with these aims in many cases.

Weak leadership and management coupled with unclear roles and responsibilities led to disputes around who performed what duties and often resulted in a stand-off between professional domains. Staff involved at grass roots level would take their grievances to respective line managers who did little to encourage co-operation or ameliorate situations, ultimately promoting the infamous claim of the health and social care divide [118, 120]. Through these destructive and unproductive attitudes and behaviours, assessments and care planning were subsequently and unnecessarily delayed. Additionally, weak leadership and management resulted in an aversion to incorporate innovative technologies in e-health as part of care package provision as recommended by the department of health and social care [24]. Consequently, valuable resources were not always employed to best effect, weakening the direction of the Scottish government's population needs mandate [22].

A lack of regular supervision was also expressed in some localities due to increasing pressures experienced by some managers. However, staff were acutely aware of the increased work-load and because of the nature of the work they are in, they were concerned for their managers also. So, at a time when reflexivity is even more important due to increased numbers, complexity of cases and general pressures of available resources, it seemed to be one of the first type of guidance to be neglected in some areas.

Clarity of vision, well defined guidelines and good communications are synonymous with successful inter-disciplinary working where leaders and managers can do much to encourage effective collaboration even in challenging times of austerity and scant resources [397]. This study found that strong leadership and effective management were able to overcome such challenges and where this was observed, greater collaborative projects developed in the analytic field. For example, over the years some local authority managers developed relationships with other data controllers from different disciplines and regions and at the time of writing were working through some exciting analytical concepts.

Insightful leaders and team managers were able to recognise talented and enthusiastic workers and were instrumental in developing their skills which not only benefited individual learning but were of greater benefit to team dynamics. For example, some social workers demonstrated notable abilities in IT and through this recognition were encouraged to attend meetings with IT developers. These consultations served as a platform to share aspects of recording routine data which resulted in changes to some social care data forms through IT system enhancements and form modifications. Speedier reporting ensued whilst at the same time duplication effort was reduced. Other team members who previously expressed little interest, became motivated which provoked further development in making IT and other resources work for everyone. Conversely, other localities made reference to IT systems having wide-ranging capabilities however, they acknowledged only a few people knew how to navigate in order to maximise systems potential. This lack of knowledge and underuse was made worse due to a lack of training where some localities offered no instruction on IT use or in local procedures when arriving into a new position or as CPD throughout their service.

It has to be pointed out that the mere existence of collaborative teams did not guarantee successful integrated work particularly with so many inter-related dynamics at force within standardisation, philosophies and leadership/management. It is of no comfort to discover the complex variables that are at odds with one other during day to day routine delivery of health and social care with seemingly no one size fits all panacea to bring about a satisfactory solution. There are many roles and responsibilities which would benefit from formal clarification despite some excellent examples of informal joint working arrangements. Given increasing workloads in every area of health and social

care, all stakeholders (clients, families, administrative, social care, health and technical staff) perspectives need to be carefully considered when policy makers adjust existing procedures or plan future health and social care integration initiatives.

10.4. Professional Boundaries

Throughout the project, it was important to pay attention to the dynamic nature of inter and intra-professional relationships between social workers and the various health staff they engaged with during joint working and also between social workers and local authority administrative staff they worked alongside. This was achieved through examining the sociology of the professions and boundary work [262,263]. These concepts help to answer research question two.

The sociology of the professions was considered a complementary analytical framework to afford further insight and strength to the study. A refined model of professional dominance theory incorporating negotiated order of boundary work were identified as being particularly useful to address those topics that ANT pay little attention to [262]. A great deal has been written of the nurse-doctor-administrator relationship over recent decades, much to the exclusion of social workers where they tend to appear around the periphery of narratives [54, 264-269]. Since social workers are integral to contemporary health care teams, the models offered the potential to tease out different inter and intra-professional relationships, power dynamics and organisational influences during information gathering and managing from a social care perspective. This type of work has not been examined in its entirety thus far. Additionally, there are a shortage of studies which explore interactions and relationships between social workers and the supporting administrative staff in local authorities who they work alongside. Therefore, by applying the same analytical framework, further interpretation and understanding could be accomplished within this wider organisational field. For example, according to Freidson and others, doctors are considered to hold more power than nurses and AHPs due to the higher status of their profession [255, 260, 350]. There is less evidence to illustrate *exactly* how social workers fit into this hierarchal field. Equally, the lack of studies from a social work perspective prompted the question of whether social care administrators were incorporated into this hierarchal field in local authority departments. Similarly, Strauss's work on negotiated order and boundary work has illustrated patterned variability in negotiations between doctors and nurses but less is known between health care staff and

social workers or social workers and the administrative staff who they work alongside [262, 266]. Thus, these concepts were applied to examine interactions between clinical staff, social workers and social work administrative staff.

As with ANT, Freidson's work on the sociology of the professions and Strauss's negotiated order have their critics. Some authors argue that Freidson's perspective of medical dominance was based in the context of a health care system (USA) that was predominantly privately funded, contributing significant weight to market competition and consumer choice of the 1970s and 1980s [408-410]. Calnan implied that this provided greater professional autonomy and freedom in contrast to the UK NHS, a nationally funded organisation where greater state control presented more constraints [408]. However, although this may have been the general thinking of the time, much has changed in the UK NHS since then. Now characterised by consumerism and managerialism in an ageing population by Bury and Taylor, the UK NHS policy had shifted closer to the USA market/consumer style movement by the turn of the 21st century [409, 411]. That said, some authors speak of a decline in medical dominance through 'bureaucratic accountability'; the formal recording of clinical activity and decisions for audit purposes [412 p.213]. Others note the competitive threat from other healthcare workers, the consequences of globalisation and the 'information revolution' [413 p.279]. Additionally, the reduced knowledge gap between doctors and the public described as 'articulate, information-rich consumers' infer that patients were no longer blindly trusting in their doctor [408 p.293]. Whilst the literature continues to debate and counter debate respective stances, medical dominance remained a useful concept to explore in recognition of the fundamental hierarchical relationship between professions. In doing so, the study was able to evidence whether medical dominance was evident. And in reality this proved the case. Medical dominance was apparent, although it was more noticeable in acute hospital settings. The scale and size of an acute medical institution may have provided more authority to clinical decisions over the much smaller social work departments that worked within such an infrastructure, amplifying power dynamics. GP centre practices, community MDT meetings and case conferences which comprised smaller (and varied) contingents of medical staff and smaller organisational spaces which may have provided a more collaborative and inclusive environment during joint working ventures.

Some criticism was directed towards Strauss in his earlier writings on professional boundaries when he suggested that everything was open to negotiation in the constitution of social order [266, 410]. Strauss even cites one of whom he calls his 'Marxist critic' who noted 'the important things are always non-negotiable' [414 p.248, 415 p.5]. Acknowledging his own clumsy articulation, he later back-pedals to modify his statement by emphasising the concept of the structural content in which negotiations take place in the processual context of the negotiation [414].

By adopting Strauss's negotiated order perspective and Gieryn's insight into intensified boundary work during times of uncertainty, this study was able to examine how social care data processes and management were impacted by the complexities of negotiation, re-negotiation, defending or expanding of professional boundaries. Negotiation processes in day-to-day practice were observed in this study and data even supported how some tasks were not open to negotiation. Through the various concepts mentioned in the literature, nurses/social workers and administrators/social workers were observed negotiating tasks through a bargaining approach, through tacit agreements, through one-off agreements and through repeated actions. These actions were dependent on each task and the situational context within the organisational structure and the people involved. Some tasks were certainly not open to negotiation, particularly if social workers were requested to assist with specific medication prompting by district nurses. Similarly, some district nurses declined to negotiate their working schedules if clients required nurse attention in their home out with their routine hours of work. These findings are consistent with Grant and Guthrie who found similar boundary-making and boundary-blurring co-existed when examining safety practices of routine work in high volume blood test results by receptionists in GP practices [269].

When reflecting on the findings of this study, two noticeable differences were found balanced against a study by Davina Allen on the nurse-doctor boundary [266]. Her study reported no face-to-face negotiations during structural changes in nurse-doctor tasks, contrary to what was found in this study. This quite rightly raised the question of whether structural changes can indeed occur without negotiation. Allen does concede however, that negotiations may have taken place in other arenas and emphasised the importance of identifying where these might take place and the impact they have on the negotiating process [266]. Svensson writes of 'back-stage' processes of negotiation, out of earshot of

a client/patient, where issues are discussed or argued to maintain a sense of public unity [267 p.397]. These spaces can include conversations in corridors, break-out areas or meetings and case conferences where these rule-changes can take place. For this study, negotiating processes between social workers/healthcare staff and social workers/administrators were apparent in many of the arenas mentioned above. These were identified through the use of ANT's network tracing activities and supported by the ethnographic approach adopted. Allen placed an emphasis and importance on the use of observational data however, despite being of great value, the method did not account for all negotiating events and it is also possible that some negotiating spaces went unnoticed or unheard during this study. For example, social workers spent an inordinate amount of time on the telephone as part of their routine work. It was difficult to interpret more nuanced ways of the negotiation process during telephone calls as it was not practical to have the telephone on speaker during these times. Limitations of the distant speaker's exact actions were therefore acknowledged.

The second issue in Allen's study was that she found ambiguities in her semi-focused data which aired concerns and disagreements in nurse-doctor changes, in contrast to her fieldwork data. This study also found that some interview data and formal documents conflicted with practice on the ground (albeit in reverse form[12]). When challenged, it transpired that in this current study, contradictory interview statements or documents did not take account of the different permutations of situational and contextual information when translating to real life practice. Allen described her interview data as 'displays of perspectives of moral forms', which I believe is consistent with the difference in what some people say they do, which is often rather different to what actually occurs in reality [266 p.514]. Interviews can be susceptible to these socially desirable responses, and although this study found some merit in this view, participants were generally very frank and forthright, highlighting positive and negative statements that were consistent with observational data. For example, issues of strong management, successful joint working and mutual respect were expressed equally as matters of poor workflow design, ideological differences and IT systems weaknesses.

[12] Allen's interview data uncovered concerns and disagreements in the nurse-doctor boundary changes, whereas her field work did not demonstrate this through nurse-doctor negotiations. This current study on the other, hand found some interview data had portrayed as an ideal rather than an actual scenario which when observed in practice revealed many nurse/social worker and administrator/social worker negotiations being enacted on the ground.

Findings in this study were able to show healthcare/social workers and administrators/social workers engaged in occupational closure strategies (demarcation/ exclusion and inclusion/dual closure). Conceptualised by Witz, the concept distinguishes practices by perceived superior and subordinate professions in the quest to protect or expand their occupational domains [355]. Doctors were perceived as more powerful, particularly in acute settings where they were observed engaging in demarcation and exclusionary tactics towards social workers. This took place during ward MDT meetings, hospital case conferences or review meetings where consultants believed their expert knowledge assumed overall responsibility of the needs of the patient in an authoritative manner. Social workers often challenged this behaviour using dual closure strategies to break downward usurpation practices and were sometimes successful. Consultants' views received support from nursing staff, clients/patients and family members who often viewed clinicians as the experts in their care need decisions, weakening a social worker's stance in many cases. Interestingly, social workers engaged in demarcation and exclusion tactics towards administrators whom they worked alongside. They were observed conducting the same patterns of power behaviour similar to consultants, whilst administrators employed the same dual closure strategies to break downward usurpation practices by social workers [355] .

Demarcation/exclusion and inclusion/dual closure strategies were less noticeable in community health settings and this is in line with Strauss's writings in that the structural features of an organisation are important factors to consider in processes of social order including the location, building design and function [414]. For example, in contrast to a more authoritarian approach to MDT meeting and case conferences in acute settings, a comparatively equal display of power was visible in community settings. Doctors, nurses, AHPs, social workers, support workers and surgery managers operated 'collegial facilitation' as opposed to an authoritarian approach, as observed by Nugus when he examined how and where doctors exercised power [348 p.901]. Community MDT meetings and case conferences in this study were for the most part relaxed affairs, although task-orientated with individual members taking responsibility for their own work. Some meetings involved coffee and snacks as a way to merge break-times or lunch with official business. By the very nature of these gatherings, more than just client cases were addressed. Staff were able to share role-specific information which was transferrable to other cases and situations. Additionally, Nugus described 'snowball tactics' during such

assemblies as facilitating opening and connecting ideas that led to other topics relative to client need and this was observed on various occasions. All of the above are interesting and important hypotheses of methodological and theoretical importance to bear in mind when examining boundary work. This study was therefore able to contribute new knowledge to the literature in areas not explored to date.

10.5. The Value of ANT

The methodological framework adopted for this study enabled examination of multifaceted layers in complex organisations such as health and social care. The approach facilitated the capture of ethnographic information in a transparent manner through rigour of methods. It is particularly important now to appraise the use and value of ANT as an analytical tool.

ANT has been applied to study organisations and places where objects or technology and other inanimate entities come into being [226, 227, 229]. Actants that actively participate in networks are afforded equal precedence (human and non-human objects) and can include but are not limited to ideas, knowledge, behaviours, individuals or groups of people, environments, policy mandates and technology. Actants can be followed to identify networks that exert force in order to examine their effects on social practices, and also how social practices impact networks. Latour describes this equivalent assumption as 'symmetry', removing the preoccupation of the structure-agency debate by rejecting the rigid separation between the two. In this study, local authorities and health boards incorporate a broad range of organisational infrastructures/substructures, IT systems, client records, a wide range of social work and clinical staff which all interconnect during information creation and management. ANT was particularly useful to help tease out every day work flows and networks of influence and was therefore a valuable approach to explore social care data collection, coding, use and management without giving superiority to any of these components.

ANT helped provide a deeper focus in the complex and rich environment of health and social care either as stand-alone organisations or as health and social care integration. ANT encouraged the deconstruction of actants to see what was going on inside them – the black box. For example, if we examine an individual attending a department or MDT meeting, we can view that individual as a network in his/her own right. This individual

brings a unique network of phenotype, genotype, personality, reputation, knowledge and skill into a larger network. Other temporal networks that are incorporated into that individual's network may include issues such as the sort of day an individual was having prior to the meeting, issues that may pre-occupy their mind prior to or during the meeting, having the correct forms or information to communicate during the meeting, personal or professional motivation and priorities, and so on. This multifaceted individual then becomes part of a larger network; the department or MDT meeting network. Depending on how he/she or indeed other humans and non-humans interact during these gatherings, will depend on the output. By viewing processes in this manner, one can begin to appreciate and unravel multiple factors that can influence network activity. For instance, there can be anything up to around twenty members that attend MDT meetings. All individuals present as unique networks who come together to perform as a whole in a specific time and place fusing with technology, infrastructure, policy and practice. These meetings are exclusive to a specific time and place and change on every occasion.

To describe further, the simple act of rolling one's eyes or waving one's arms in the air are relatively common physical actions. However, examining each interaction with other networks provided a precise and refined analysis of a network at force. Rolling one's eyes could be viewed as a humorous gesture, a nonthreatening movement or indeed an insult. Similarly, waving one's arms in the air could be viewed as aggressive or frustrated behaviour, an aid to direction or even a symbol of joy. A ward manager struggling to negotiate a faulty smart-screen dashboard during an MDT meeting brought about an assortment of these gestures, however each were performed differently by different actants. ANT therefore offered the ability to zoom in and unpick precisely what networks actually did, which provided a powerful tool for describing what was occurring when clusters of networks came together as witnessed during many MDT meetings.

It is worth pointing out that when first studying ANT, I found an abundance of hyper-theoretical publications explaining what seemed a very complex model. Additionally, there was very little in the literature to demonstrate the practicalities of 'doing' ANT. Many articles presented complicated language, accentuating what now seems a very simple, but difficult concept to articulate. For instance, some critics highlight a lack of guidelines in terms of who and what to follow (prime movers) and where to stop [242-244].

This limitation was resolved by combining ANT with the ethnographic approach adopted for the study. Key concepts such continuous reflexivity, being there in the moment to gain an insider's view of the action in context, alongside the arrangement of a multiple-site enquiry to support the sequence of intense following and knowing where and when to stop. Additionally, the aims and objectives of the study which were clearly formulated operated as important prompts when working in the field, ultimately serving to ensure answers to the research questions were obtained.

In reviewing the literature, some key restrictions of ANT were worthy of consideration when attempting to answer the research questions. For example, critiques argue that whilst acknowledging (although not necessarily agreeing) ANT's challenges of dualism between the social and natural, there is much debate on how alliances and networks alone can reflect the social world [237, 250]. This point is particularly pertinent since many other phenomena are at force during social care processes which are largely neglected by ANT alone. For example, Star emphasises a problem in the distribution of structures and hierarchies which are essentially ignored in the ordering of ANT reports [252]. Her modest examples of an executive who becomes the center of a network yet the very people who enable the position are erased; or the plight of someone ordering a burger at McDonalds but who is allergic to onions explains the dilemma of being excluded in a novel manner [252]. Additionally, Whittle and Spicer argue that whilst ANT can offer a valuable framework for empirical analysis of the organisational process, it cannot provide a critical account of organisational structure [253]. ANT therefore, powerfully describes what is taking place but offers no explanation as to why.

Thus, when consideration is given to health and social care organisations, both of which are very hierarchal in structure and function, could leave ANT somewhat wanting. Introducing a complementary understanding of hierarchal structures and behaviours besides historical and organisational concepts could help to better inform social care data collection, use and management. Thus, as predetermined and pre-existing social structures, their historical backgrounds are given little notice in ANT, many support the notion of using ANT alongside other theoretical frameworks [237, 245, 401, 402]. As a result, Greenhalgh and Stones adopted strong structuration theory in a pragmatic hybrid theoretical framework with ANT to address questions of policy and practice in healthcare systems [403]. Similarly, through multi-level analysis of the organisational

field, Currie and Guah demonstrated historical changes (professionalism, managerialism and market mechanisms) over time which influenced NPfIT in the UK NHS which could not be attributed through ANT alone [404]. Some sociologists go as far as to say that network constructions are intrinsically and historically dependent no matter how stable or otherwise [252]. Therefore, by not taking account of these phenomena, ANT in isolation could limit the analysis of how the historical influences networks. This vulnerability had particular implications for exploring social care data processes since health and social care organisations have distinct structures, each holding a long, historical and independent past.

From a health and social care perspective and in order to answer the research questions, the solution it seemed and in agreement with the literature, was not to dismiss ANT totally as the approach has many advantages as aforementioned. But rather to utilise ANT's network tracing potential alongside the introduction of other social theory concepts into the analytical framework [32, 405-407]. Examining pre-existing structures, historical and hierarchal influences relevant to social care data processes through the sociology of the professions provided a richer understanding and complemented analysis in context of network activity. As Miller points out when reporting a field of enquiry 'the writing of which cannot be guided by a single method any more than the art of travelling can be specified in advance' [244 p.356]. In other words, the experience cannot be felt until the journey begins.

Other reports cite the requirement to be agnostic (or detached) from an ANT perspective and some find fault with this stance [250]. As Collins and Yearley point out, the analyst remains in control making detachment seem somewhat counter-intuitive [250]. A researcher cannot be absolutely indifferent to the research process although impartiality is a serious consideration as noted in 3.6. However, this position is not confined purely to ANT but is of a larger epistemological debate in qualitative enquiry [47, 204]. That said, the role of the researcher is discussed further in 4.5 to explain what steps were taken to view actions from all actants points of view.

In summary, using ANT was a powerful tool to help describe actants and networks in a precise and minute manner making visible the messiness and multi-dimensional measures at force in complex organisations such as health and social care. The

ethnographic approach in combination with ANT bolstered rigor of methods through transparent and replicable means. Consequently, ANT and ethnography demonstrated exactly what happened during interactions with human and inanimate objects during data collection and management processes. The sociology of the professions helped to explain why.

10.6. Areas for Improvement

In consideration of the findings from this study, there are consequences with regard to health and social care integration policies, procedures, education and training that could serve as further stimuli to aid direction of successful amalgamation. The collective attributes of Standardisation, Philosophies, and Leadership/Management within the wider health and social care policy landscape proved instrumental in the research findings. Results demonstrated that data collection processes and management were more cohesive when standardisation, philosophical stances and leadership/management styles operated from shared rather than opposing values. Where opposition ensued, breakdowns in data processes occurred and more importantly, client care was adversely affected. Reflecting upon the intricate blend of inter-related factors from Figure 10 (p251), there is an urgency to develop programmes for improvement. Demand for health and social care services are expected to continue to grow therefore the following suggestions are aimed to make services more streamlined and cost effective. Additionally, many of the measures proposed are pragmatic and need not break the constrained health and social care fiscal agenda.

Table 9 begins with consideration to the wider health and social care integration policy in context. The recommendations, if implemented, would have a disseminating effect that would positively impact the three attributes; standardisation, leadership/management and philosophical stances. The first proposed strategy to align working terms and conditions would help to dissolve contentious issues currently experienced by health and social care staff. For example, health and social care staff would have equal opportunity for career advancement and so the best candidate would be awarded the position, rather than an applicant being appointed through the imbalanced selection process that stands at the moment. Having matching and clear policy mandates would eliminate the current confusion in who can share information and who cannot, particularly in relation to risk management. Transparent guidance

would give staff confidence to develop better ways of working. Joint ventures may also be easier to implement as a result. The creation of joint funding sources could encourage better problem solving as a shared undertaking, utilising whatever resources were available during care planning. This strategy would also help to bridge the gap in perception between the two organisations, especially given the poor opinion held by the general public in relation to social care. The development of workshops that enable a greater understanding of each professions priorities and burdens would help to ease present tensions and foster better collaboration. Most health and social care staff are passionate about their desire to care and are eager to create new ways of working. However, without the environment to support inspiration, managers and staff are unable to apply their enthusiasm to any meaningful effect.

Table 9. Measures that may benefit from being re-examined following findings from this study that map onto parts of data flow diagram in Figure 10 (p251).

Category	Scope for Improvement
Health and Social Care Integration and Wider Policy Context	**Align policies to ensure equal terms and conditions of employment, career advancement and job security in joint working positions.** **Clarify and communicate data sharing protocols that result in better data collaboration.** **Align systems of funding to limit contentions around the health and social care divide.** **Develop policies and initiatives that encourage recognition and understanding of the tensions between collaboration and competition during partnership working.** **Provide environment that permits time for practitioners to become more creative in new ways of working.** **Develop strategies that enable analysis of client case notes to bring attention to potentially important contextual factors when evaluating care pathways.**
Standardisation	**Further evaluation and standardisation of social care referral forms between health and social care to assist with smooth, efficient and accurate transfer of client information, including reviewing language and terminology usage, type and volume of information required.** **Remove ambiguous questions and improve understanding of information required in social care forms and procedures.** **Create procedures that take into account restricted IT system interconnectivity and limitations of other hardware facilities during routine collection of health and social care information.**
Leadership/Management	**Develop workshops that inform the importance of information gathering and that promote the consequences of data that are collected in a timely, accurate and consistent manner.** **Support team leadership and management strategies to boost joint team working.** **Provide adequate staff training to enable social care staff appropriate knowledge and understanding of local authority IT systems and local operating procedures.**
Philosophies	**Develop and promote inter-professional training programmes that explore different roles and responsibilities and the subsequent tensions and barriers that ensue across different professional boundaries in relation to health and social care integration.** **Explore inter and intra-disciplinary team processes and procedures that enable greater inter-professional working conditions.**

10.7. Ethnography

Ethnography, which has gained popularity in health and social care studies served as the basis to enable full consideration to how people under study understand their social world from their lived experiences [32, 33, 49-51, 55-58]. An ethnographic methodology was adopted to enable the exploration of social care data processes and for topics to emerge from data gathered. Contextual, contingent and reflexive understandings of social organisation resulted inductively employing an interpretivist model which ethnography affords in stark contrast to a positive paradigm [47, 48]. This allowed me to describe explicit and tacit beliefs by studying participants in their ordinary place of work in this bottom-up form of inquiry. A here and now portrayal of unfolding events was captured; individually and collectively experienced which can be considered a strength of this study. By following the principles of ethnography; lending thought to and acknowledging potential sources of subjectivity or prejudice helped me to remain faithful to reporting events from the people themselves as occurrences unfolded. For instance, when observing front line social workers, I grew to appreciate the difficulties they experienced when trying to conduct their routine work according to social work principles. I noticed I was becoming sympathetic to their ordeals, and so I then had to take stock and view each situation from everyone's perspective. For example, health, administrative and technical staff were also striving to accomplish their routine work from their own principles and priorities. This realisation was an important milestone moment for me in terms of remaining impartial throughout the study.

A multi-site ethnographic approach was selected to allow local contextual issues to emerge as well as to provide an overall depiction and comparison of processes across regions [49, 279, 280]. The sampling method for this study provided information-rich individual case studies in order to explore social care data processes in each site's natural context. Studies were then compared across sites to explore shared and distinctive experiences and views. The study was also able to report important dynamics between and across health and social care and where findings across case studies allowed valuable lessons to be learned. Interviews and observations were conducted in parallel with synthesising and analysis and offered many instances to compare and contrast day to day events. Transcripts were continuously read, re-read, and reflected upon. For example, one interview participant mentioned good and reliable inter-connectivity with IT systems that enabled workers to access client information remotely. However, the reality

of this statement in practice was rather different. For instance, in theory, staff were indeed able to access information from a distance, but practical issues such as staff being unable to obtain the required equipment in order to do this, or where intermittent or weak internet signal strength made this an ideal rather than actual in many cases. Additionally, only one local authority of the three offered this 'theoretical' function, although plans to introduce remote access capability in the future was talked about by staff at the other local authorities.

The positivist literature would argue that case studies are a poor basis for generalisation and that the views and experiences expressed in this study remain specific to these areas and may not be representative of the full range of opinions and encounters that exist in other areas [(398)]. However, I and most qualitative researchers would argue that a strong theoretical framework allows theoretical generalisations on the basis of well-conducted case studies [(399)]. There is a rationale to label what Stake refers to as 'petite generalisations', and following this principle, analysis was able to show generalities that occurred within and across these collective cases [(399 p.7)]. I would argue that there is justification to provide more than just 'petite generalisations' from the findings of this study. When I compared data across fieldsites, each of the three local authorities enjoyed many related successes as well as having to confront similar challenges. Yes, the empirical settings were unique, however, I believe lessons are transferrable and relevant to other areas of health and social care and perhaps beyond. For those who hold the view that these data cannot provide generality, the research protocol has been clearly defined, and can be replicated across additional areas in order to explore other potential factors of influence. Scotland and England have 32 and 326 council districts (respectively) therefore, the study procedure could also serve as a basis and offer scope for further investigation in the UK and elsewhere.

Participant sampling for this study applied purposive followed by snowball sampling and was instrumental to ensure breadth, depth and scope; rich in diverse perspectives in order to maximize heterogeneity in views and experiences. It is worth bearing in mind that sample size can be difficult to specify at the outset in qualitative research where normally only estimates can serve as the best calculation. The common criteria proposed in the literature relies not on numbers, rather when data saturation has been reached [(400)]. Stake suggests the first criterion is to maximise what we can learn through the

importance of achieving balance and variety [399]. Participant sampling in this study benefited from combining purposive and snowball methods which provided continual mechanisms to recruit participants until saturation was reached [398]. Ultimately, there was the possibility that some participants went unnoticed, who may not have been so well connected, and whose views and experiences were subsequently not considered. Additionally, not all departments within each local authority participated. It is possible that these may have developed more cohesive or indeed dysfunctional team dynamics that were not accounted for. However, I had the unusual dilemma of being over-subscribed by offers of participant support, and so careful consideration was devoted to who would be able to provide the most appropriate information in context of each specific issue of interest. Following actors in accordance with ANT network tracing activities assisted during these occasions, and is discussed further in 10.5.1.

This study did not examine processes from the views of clients/patients their families or carers in any great depth and may be viewed as a weakness of study findings, particularly given person-centred principles and preferred stakeholder involvement. In hindsight, this is a great pity and a missed opportunity. Clients/patients were not interviewed as the focus of the study questions were directed towards data pathways affording little time to gain in-depth views from clients. Of course, clients/patients, family members and carers contributed valuable comments during the great number of client assessments, case conferences and review meetings. However, these were analysed from the researcher or assessor perspectives only.

Another weakness of this study refers to the fact that clinical staff were not interviewed. Again, the focus on social care data processes prevented such interviews although there was an abundance of interactions between health and social work staff on ward settings, in the community including care/nursing homes, GP health centres and MDT meetings. These interactions provided a wealth of knowledge and understanding to respective discipline routine practices. Additionally, there is a considerable body of health research that encompasses nurse and doctor views. This is contrary to social care information, which is lacking in the literature, and hence the motivation for a strong social work focus. Views from third sector agencies or wider local authority agencies (i.e. housing, criminal justice) were not explored. These topics did not surface during observations or interviews other than brief encounters at an operational level. Our understanding of how

these factors influence information processes across wider health and social care are therefore limited.

The ethnographic method incorporated data triangulation to offer a multifactorial explanation of people's views, experiences and actions in their described world [196, 281, 283]. Different data sources helped to support the trail of events and happenings; confirming, re-living, re-examining and re-assessing experiences. For example, single approaches to data collection can bring methodological weakness to a study. However, different data sources may have different methodological weaknesses, thus combining data techniques can improve research quality and findings [281, 282]. For example, Davina Allen noted how Roland Svensson contributed important understandings to doctor and nurse interaction patterns however, his analysis was constrained as he used interview data only, offering a partial view [266]. Applying three data sources is therefore considered a strength of this study and ensured an all-encompassing representation of health and social care through first hand observation (non-participation), semi-structured interviews and documentary analysis. As Svensson himself acknowledged, complementary data such as observations and discourse analysis are important methodologies to consider in the empirical analysis of negotiated order [267]. Madden also proposed much background reading to complement these 'storied realities' which in his view served to 'fatten up an ethnographic data set' [222 p.170].

During observations, front-line social care staff at each local authority talked me through the client assessment process which seemed to provide a uniformed practice across field-sites. However, when collecting supporting documents, and through further observations, it became apparent that numerous different formal assessment forms were used making consistent information collection unlikely (Table 4). Additionally, as ongoing observations revealed, most social workers did not use these forms during the actual client assessment and instead created their own individual template that was then translated to an official form at a later date.

I remember it was not always straightforward obtaining supporting documents. Some workers did not know how to print out blank versions of forms from their case management system, or did not know if I would be authorised to have them. In these instances, it was suggested that I request specific forms from service or data managers.

Keeping a track of what was collected and what was still required called for an organised and re-organised list of 'things to do' each day. Information gathered from some interviews conflicted with what was witnessed during observations. When these were probed, more often than not the context in which data were gathered gave rise to further explanation, thus eliminating anomalies in most cases. Where no explanation could be offered, these differences were noted in the results section. Data triangulation was ultimately accomplished, but not without some challenges.

The ethnographic approach offered merit towards the aims and objectives of the study. The discussion demonstrated strengths and challenges experienced throughout, making findings in context of events transparent. The next section appraises the theoretical implications of actor-network theory and the sociology of the professions to offer further insight to those approaches.

To summarise the methodological and theoretical concepts, the ethnographic approach provided the framework to capture day to day experiences enacted by health and social care staff from the perspective of the individuals themselves through detailed in-depth engagement and in the researcher being there in the moment. ANT enabled network tracing activities in order to investigate multiple interactions at force. The sociology of the professions and medical dominance provided a complementary framework in which to explore and expand our understanding of professional authorities, bureaucracies, hierarchal structures and historical contexts. Strauss's negotiated order was able to disentangle the real from ideal by observing interactions through the negotiated order perspective. These combined concepts were subsequently able to unravel the complexities and realities of organisational, professional and systems processes, interactions and relationships during social care data origins and pathways.

10.8. Areas for future research

This thesis was written on the cusp of health and social care integration formally going live during 2016 and provides the status quo to social care data processes across three local authorities in Scotland. Believed to be the first of its kind to evaluate social care data in the UK – from origins to output, this study highlights strengths and weaknesses of entire social care data processes with health and social care integration in mind. It is important to point out that over the course of the project great strides had been made in

terms of data access, use, quality, management and analysis with ongoing and planned projects likely to reap further benefits.

This project adds to the dearth in studies which explore social care information processes with health and social care integration in mind. An insight and an awareness of entire social care information provenance was offered, highlighting strengths and weaknesses throughout. Inter and intra-professional relationships between health and social care staff were investigated, particularly from a doctor-nurse-social worker perspective and also from social workers and the local authority administrative staff who they work alongside. This thesis does not suggest that the scope for improvements noted above are a panacea for successful social care data processes. Neither does it suggest they are the Holy Grail to achieve successful health and social care integration. They are however, pragmatic considerations in the journey to move forward to more streamlined social care data pathways in order to become closer to absolute health and social care integration.

Given this study sought to understand social care data process and practices, and following some recommendations offered, the landscape is ripe in numerous areas for future research. For example, this study explored views and experiences of social care data processes and management from three local authorities in Scotland. It would be useful to investigate findings across other regions and contexts to establish if discoveries were generalisable. There may be value in viewing different contextual relationships that did not emerge from this study through further qualitative inquiry. In a similar vein, a quantitative project could be developed, using existing findings to make assumptions in the form of an intervention or questionnaire in order to test hypotheses across a greater number of districts.

An immediate next study could involve the development of a more streamlined referral process that feeds into hospital discharge teams from ward settings. Current processes are fragmented, disparate with no consensus on delivery procedures or what information should be included on referral forms. Patient care pathways are often delayed and adversely affected. This study would directly build on this thesis by addressing this specific weakness discovered during investigations. The research would encompass health and social care staff operating at the front line but the project would also require co-operation and input from wider health and social care data managers and policy

makers. Taking the view that collaboration needs a clear and shared vision, any new process would have to be mutually agreeable, workable and improve existing procedures [394]. At the outset, this research could explore the opinions and experiences of health and social care staff who are directly involved in the referrals process at acute settings. Once clarified, discussions could be held on how best to improve the existing practice. This research could perhaps take the form of an action research methodology which can be applied to solve organisational problems. Action research (AR) is a form of social research which involves people in a process of change, a bridge between theory and practice; and in the words of Winter and Munn-Giddings 'a process which alternates continuously between inquiry and action.' [416 p.5] Once views were summarised and considered, an exemplar protocol could be developed and tested initially on one ward within an acute setting. Then depending on findings be refined and re-examined. Once the new process was deemed feasible, deliverable and acceptable to everyone involved, a further study could compare its application with other wards employing the existing system. Outcome measures could include reporting patient care provision timings from admission, hospital delayed discharge rates and patient satisfaction.

In the longer term, further research could also explore the views of the very people who use health and social care services and who are at the centre of the data collection process; patients/clients, their families and carers. Such participants could contribute a constructive and additional contextual insight to information processes besides encompass the government's aspiration to a whole system approach, person centred care principles, and wider stakeholder involvement [22].

Future research could also explore the use of client case note information for analytical purposes as these were underused at the time of writing. Expertise in discourse analysis or comparable framework would be required but this was found to be lacking in local authorities when the matter was discussed during interviews. This study was unable to develop a deeper understanding of their potential use due to a strong focus on the research questions combined with schedule pressures. Future research in this area could prove beneficial, for instance in tracing potentially important information currently not collected in coded format.

During this study, the researcher actively engaged with participants for a period of 18 months and then communication continued with key workers for approximately one year afterwards. However, one has to be reminded that this project was in essence a snap-shot view of data processes at force at a specific time and place. Longitudinal research would therefore be invaluable in order to investigate and map the fluidity of health and social care realities during professional, organisational, economic and political activities in this rapidly changing landscape. For example, this study found boundary-making and blurring impacted information processes. There is no doubt health and social care integration will continue to evolve with a strong possibility that health and social care staff will assume additional roles and responsibilities as well as be released from some existing duties. Changes in responsibilities bring adjustments to professional identity and boundaries [272]. Boundary work research within social care and across health and social care services could therefore prove instrumental in reporting the negotiated order of these changes. Variations that may occur across different forms of organisational care could also be examined, as in the work of Svensson who investigated the negotiated order of the doctor-nurse relationship on wards over a decade [267] .

There is also potential to perform other longitudinal research, particularly at site one following the procurement of a new IT system which was installed after interviews and observations. Findings from site one resulted from an IT system that was about to be de-commissioned. It was therefore not possible to explore how the installation of new technology was embedded into operational practice. Given the in-depth understanding of their existing system, future research could examine processes involved at inception of the new structure and then over time; moving forward during the various stages of embedding practices. Examination could also consider the power dynamics that may accompany such a project and provide valuable lessons for future health and social care IT commissioning and implementation enterprises.

11. REFERENCES

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APPENDICES: Appendix 1: Ethical Approval.

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Clinical Reader
University of Dundee
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Date: 09 October 2015
Your Ref:
Our Ref: LR/15/ES/0117
Enquiries to: Mrs Lorraine Reilly
Direct Line: 01382 383878
Email: eosres.tayside@nhs.net

Dear Dr Witham

Study Title: **Exploring contexts, processes and implications of social care data creation, coding and linkage - an ethnographic study. V 1.0.**
REC reference: **15/ES/0117**
IRAS project ID: **173189**

Thank you for your letter of 01 October 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair and designated Committee members.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Lorraine Reilly, eosres.tayside@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering letter on headed paper [Covering Letter]		03 July 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Study Insurance]		13 July 2015

Interview schedules or topic guides for participants [Topic Guide]	1.0	15 May 2015
IRAS Checklist XML [Checklist_01102015]		01 October 2015
Letter from funder [Funder Letter]		17 March 2014
Letter from sponsor [Sponsor Letter]		23 June 2015
Other [GCP Certificate Anne Canny]		17 September 2015
Other [Dr S Grant CV]		30 September 2015
Other [Evidence of Sponsor Insurance or Indemnity]		13 July 2015
Other [Dr M Witham Response Letter]		01 October 2015
Participant consent form [Consent Clients/Family]	1.1.	19 August 2015
Participant consent form [Consent Interview]	1.1.	19 August 2015
Participant consent form [Consent Observation]	1.1.	19 August 2015
Participant information sheet (PIS) [PIS Clients/Family]	1.1.	19 August 2015
Participant information sheet (PIS) [PIS Interview]	1.1.	19 August 2015
Participant information sheet (PIS) [PIS Observation]	1.1.	19 August 2015
REC Application Form [REC_Form_10072015]		10 July 2015
Research protocol or project proposal [Protocol]	1.0	15 May 2015
Summary CV for Chief Investigator (CI) [Miles CV]		03 July 2015
Summary CV for student [Anne CV]		03 July 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/ES/0117	Please quote this number on all correspondence

Yours sincerely

pp
Ms Tara Graham
Chair

Email: eosres.tayside@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms Canny
Dr Grant
TASC
NHS Tayside R&D office

Appendices 2a, 2b, 2c: Participant Information Sheets

Study Title: Exploring contexts, processes and implications of social work data creation, coding and linkage – an ethnographic study.

Participant Information Sheet (Interview)

You are cordially invited to take part in a research project that is being conducted by the University of Dundee as part of an educational qualification. However, before you decide whether or not you wish to become involved, it is important that you understand why we are conducting the research and what taking part would mean. Please read the following information as it provides you with details to help you with your decision. If you feel you require further information or clarification please do not hesitate to contact the principal investigator via telephone or email listed at the end of this information sheet.

What is the purpose of the study?

As NHS or District Council associates, you will be acquainted with the Scottish Government's integrated Health and Social Care strategy. The initiative is particularly relevant for people with long term multi-morbidities and disabilities, many of whom are older people. A great number of elderly people in receipt of social care also require services from NHS primary, secondary and tertiary care. This requires a co-ordinated approach in order to benefit outcomes for older people and also to maximise already stretched public sector resources.

Combining routinely collected health and social care records is considered key to delivering this strategy. However, results from analyses of linked data is dependent upon the information that is provided by health and social care professionals, largely through the Single Shared Assessment or its local equivalent. Current research suggests that the completeness, quality and limitations of these data are not well understood and that barriers to rapid, effective integration of these datasets exist. Collecting information efficiently and effectively is essential if it is to benefit the patient/client, service planning and delivery.

We would like to hear your opinions regarding routinely collected patient/client information and data linking. This includes any experiences you may have had whether from the forms that are used, the amount of information that is collected, the manner in which it is coded, or any other encounters you feel may affect quality, depth and usage. You may have experienced situations that make data collecting challenging and inefficient; you may have ideas that could help make data collection and linking more effective; or you may have implemented procedures to resolve local or regional differences. Whatever experiences and views you hold, we would like to hear from you.

Why have I been invited?

As a member of [redacted] Social Work department, you will be closely associated with routinely collected patient/client information and usage. It is important that we hear your views and experiences in order to understand processes involved. We would like to hear from a range of professionals from health and social care sectors so that a complete understanding can be achieved.

Do I have to take part?

Participation is purely voluntary and you can accept, decline or withdraw without any explanation, although we do hope you will be able to help with this worthwhile project. If you decide to participate, we will ask you to sign a consent form. You will also be given the opportunity to query any uncertainties you may have. You will be provided with a signed copy of the consent form and the University of Dundee would hold a copy in their files.

What would my participation involve?

You would be interviewed during working hours on a one to one basis at a mutually agreed date, time and location by one of our researchers. The interview will last approximately 1 hour and would involve asking for your opinions and experiences of data collecting, linkage and usage. A topic guide with questions will be provided in advance so that you can think about your answers prior to the meeting.

What are the possible benefits of taking part?

There are no direct benefits of taking part in the study. However, we would hope that being involved will present a greater understanding of data linking analysis processes

and how information you provide affects wider health and social care policy and future provision. Experiences you offer will contribute to a wider understanding of routinely collected data, its usage and data linkage. Such information is crucial in order to build a robust evidence base that supports service planning, delivery and comparison.

What are the possible risks of taking part?

There are no risks associated with this study.

What will happen to the information that I provide?

The interview will be audio-recorded so that what you say can be documented, transcribed and analysed accurately. The audio recording will be destroyed once transcription has been completed and checked. The information you provide will be anonymised so that you will not be recognized by others. You will be allocated a unique 3-digit participant number and any corresponding identifiable information will be kept separately in a password protected computer at the University of Dundee.

Your information will be kept confidential and no one will have access to your personal details other than the research team at the University of Dundee. The information you provide will be used to form an article to be published in a medical, social policy or informatics journal. Findings from the study will also be presented at scientific meetings. You will not be identifiable from any of the data or results. Anonymised data from the study will be held for 7 years and possibly used for future research purposes by other academic or research institutions.

What if I have a complaint?

In the unlikely event that you are unhappy with any aspect of the study process, you are advised the following:

If you believe that you have been harmed in anyway by taking part in this study, you have the right to pursue a complaint and seek any resulting compensation through the Tayside Medical Science Centre (TASC) who are acting as the research sponsor. Details about this are available from the research team.

If you are a patient of NHS, you have the right to pursue a complaint through the usual NHS process. To do so, you can submit a written complaint to [redacted]

[redacted] *Please note that the NHS has no legal liability for non-negligent harm. However, if you are harmed and this is due to someone's negligence, you may have grounds for a legal action against* [redacted] *but you may have to pay your legal costs.*

What do I need to do now?

You do not have to do anything at the moment. Our contacts at each Health Board and District Council will notify us of your initial willingness to take part. Our researcher will then contact you to arrange an informal meeting to discuss the study further. This will also give you the opportunity to query any uncertainties you may have.

Who has reviewed this study?

The East of Scotland Research Ethics Committee (REC2), has responsibility for scrutinising all proposals for medical research on humans in [redacted]. They have examined the proposals and have raised no objections from the point of view of medical ethics. It is a requirement that records in this research be made available for scrutiny by monitors from Tayside Medical Science Centre (TASC) whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

For further information please contact the principal investigator:

Ms Anne Canny
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Appendix 2b, Participant Information Sheet (Observation)

Study Title: Exploring contexts, processes and implications of social work data creation, coding and linkage - an ethnographic Study.

Participant Information Sheet (Observation)

You are cordially invited to take part in a research project being conducted by the University of Dundee as part of an educational qualification. However, before you decide whether or not you wish to become involved, it is important that you understand why we are conducting the research and what taking part would mean. Please read the following information as it provides you with details to help with your decision. If you feel you require further information or clarification please do not hesitate to contact the principal investigator on the telephone number or email listed at the end of this information sheet.

What is the purpose of the study?

As a front-line District Council social worker, you will be familiar with the Scottish Government's integrated Health and Social Care strategy. The initiative is particularly relevant to people with long term multi-morbidities and disabilities, many of whom are older people. A great number of elderly people in receipt of social care also require services from NHS primary, secondary and tertiary care. This requires a co-ordinated approach in order to benefit outcomes for older people and also to maximise already stretched public sector resources.

Combining routinely collected health and social care records is considered key to delivering this strategy. However, results from analyses of linked data is dependent upon the information that is provided by health and social care professionals, largely through the Single Shared Assessment or its local equivalent. Current research suggests that the completeness, quality and limitations of these data are not well understood and that barriers to rapid, effective integration of these datasets exist. Collecting information efficiently and effectively is essential if it is to benefit the service user, service planning and delivery.

We would like to understand the entire processes involved during routine collection of client information. This will require a detailed observation aimed to clarify how assessment, coding and decision-making are conducted. Observing can provide a detailed description in a natural setting offering an in-depth understanding of contextual factors of influence.

Why have I been invited?

As a front-line social worker at [redacted] social work department, you will be closely associated with routine collection of client information. It is important that we hear your opinions and experiences in order to understand the entire processes involved. You may have experienced situations that make data collecting challenging and inefficient; you may have ideas that could help make data collection and linking more effective; or you may have implemented procedures to resolve local or regional differences. Whatever experiences and views you hold, we would like to hear from you.

Do I have to take part?

Participation is purely voluntary and you can accept, decline or withdraw without any explanation, although we do hope you will be able to help with this worthwhile project. If you decide to participate, we will ask you to sign a consent form. You will also have the opportunity to query any uncertainties you may have. You will be provided with a signed copy and the University of Dundee would hold a copy in their files.

What would my participation involve?

The researcher would observe you during your typical daily tasks. You will be asked to 'talk through' your activities and you will also be asked to think out loud, when it is appropriate to do so whilst you conduct your work. The aim will be to capture your thought processes while you conduct your work which will help to contribute in-depth meaning to your decisions.

With your permission, observations will be audio recorded when it is feasible and acceptable to do so. Recordings will be anonymised and transcribed before analyses. Information provided will also aid recall of events for the researcher. The researcher will take field notes when it is reasonable and appropriate to do so. These will be anonymised and typed up in full immediately after each observation period.

The observation period will last around 2-3 days but this time frame is flexible depending upon the information gathered, but also to take account of your other commitments. The meetings also make possible informal discussions as a means of clarifying any misunderstandings the researcher may have.

Observation periods will be performed at a mutually agreed date, time and location. The researcher has held discussions with a range of front-line social workers and is mindful of what might be described as a routine day. Whilst it is not possible to predict every situation, these discussions have identified the most anticipated scenarios: client assessment, case meetings, professional meetings and administrative tasks.

Consequently, it would be helpful to identify individuals expected to be present during such situations in advance so that we can gain consent prior to the observation period. We ask that you first view your diary to determine a suitable 2-3 day period where you have scheduled typical tasks (i.e. client assessment, professional meetings, administrative tasks). We would then ask that you distribute a study information sheet to pertinent individuals who may be present during these times so that they can decide whether they wish to be present, as follows:

Clients: We would ask that you read through the information sheet provided with clients prior to the day of the meeting. If they are agreeable, the researcher will attend the meeting and read the information to them once again to make sure they understand what the researcher's presence means for them. They will be given the opportunity to ask questions before signing consent. If clients do not wish to consent, then the observation for that particular phase will not proceed and the researcher will leave.

We believe it is fitting to ask your client if they would prefer to have a friend, family member or someone they trust to attend the meeting also. This might negate any potential for the client to feel outnumbered or uncomfortable. If your client is agreeable to this, we would like you to give identified individuals the provided information sheet and consent form in advance. When the researcher arrives at the meeting, she will read the information through with them to ensure they are aware of what their presence means before seeking written consent.

Co-workers: There may be occasions where co-workers will be present whilst you conduct routine tasks. We would ask that you discuss the study with co-workers so that they can decide if they wish to be present during observations. They may receive a copy of this information sheet is wished. If co-workers do not wish to be present, the

observation will still proceed, however information from interactions between the objecting co-worker and yourself will not be gathered. Co-workers are encouraged to contact the principal investigator via telephone or email to ask any questions they may have.

Professional meetings: We would ask that you discuss the study with the chairperson of your scheduled meeting so that a decision can be made whether to allow the researcher to be present in advance. The chairperson is invited to contact the principal investigator via telephone or email to ask questions and if wished, they may receive a copy of this information sheet. If agreement is reached, the researcher will ask the chairperson to announce the study at the beginning of the meeting in order to gain verbal consent from attendees. In the unlikely event that consent is not gained from some attendees, the meeting will still go ahead, but any interaction between the observed social worker and any objecting member will not be documented.

General: It is not feasible to inform every person of observation periods in advance particularly since some individuals may show up to your office unexpectedly. However, we have developed a general study information sheet for display on office door entrances to accommodate such instances. Where possible individuals will be able to ask any questions they may have.

What are the possible benefits of taking part?

There are no direct benefits of taking part in the study. However, we would hope that being involved will present a greater understanding of data linking analysis processes and how information you provide affects wider health and social care policy and future provision. Experiences you offer will contribute to a wider understanding of routinely collected data, its usage and data linkage. Such information is crucial in order to build a robust evidence base that supports service planning, delivery and comparison.

What are the possible risks of taking part?

There are no risks associated with this study. However, it is acknowledged that some people may feel that the researcher's presence may be intrusive. The researcher will be sensitive to this throughout and if there are instances where you do not feel comfortable, she will step away in an unobtrusive manner until you feel able to resume.

What will happen to the information that I provide?

The audio-recorded information will be anonymised and transcribed prior to analysing. The information will also be used to aid recall of events for the researcher and recordings will be destroyed once transcripts have been completed and checked. Field notes will be anonymised so that you will not be recognized by others. You will be allocated a unique 3-digit participant number and any corresponding identifiable information will be kept separately in a password protected computer at the University of Dundee. Your information will be kept confidential and no one will have access to your personal details other than the research team at the University of Dundee.

Information you provide will be used to form an article to be published in a medical, social policy or informatics journal. Findings from the study will also be presented at scientific meetings. You will not be identifiable in any of the data or results. Anonymised data from the study will be held for 7 years and possibly used for future research purposes by other academic or research institutions.

What if I have a complaint?

In the unlikely event that you are unhappy with any aspect of the study process, you are advised the following:

If you believe that you have been harmed in anyway by taking part in this study, you have the right to pursue a complaint and seek any resulting compensation through the Tayside Medical Science Centre (TASC) who are acting as the research sponsor. Details about this are available from the research team.

If you are a patient of NHS, you have the right to pursue a complaint through the usual NHS process. To do so, you can submit a written complaint to [redacted] *Please note that the NHS has no legal liability for non-negligent harm. However, if you are harmed and this is due to someone's negligence, you may have grounds for a legal action against NHS* [redacted] *but you may have to pay your legal costs.*

What do I need to do now?

You do not have to do anything at the moment. Our contacts at each District Council will notify us of your initial willingness to take part. Our researcher will then contact you to arrange an informal meeting to discuss the study further. This will also give you the opportunity to query any uncertainties you may have.

Who has reviewed this study?

The East of Scotland Research Ethics Committee (REC2), has responsibility for scrutinising all proposals for medical research on humans in [redacted] They have examined the proposals and have raised no objections from the point of view of medical ethics. It is a requirement that records in this research be made available for scrutiny by monitors from Tayside Medical Science Centre (TASC) whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

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Appendix 2c, Participant Information Sheet (clients/family members)

Study Title: Understanding Social Care Information Collection Processes.

Study Information Sheet

(clients/family members)

The University of Dundee is interested in studying social workers whilst they carry out daily tasks as part of an educational qualification. This means that a researcher will follow a social worker while he/she does their job. You are being given this information sheet as your social worker has mentioned that you are likely to have a meeting during the observation period.

It is important that you understand what this means so that you can decide whether to allow the researcher to be present during your meeting. Your social worker will go through this information sheet with you so that you can make your decision.

If you are agreeable, your social worker will let the researcher know the date, time and place of your appointment. The researcher will read through this sheet with you again on the day of the meeting so that she can make sure you understand what her presence means for you.

What is the purpose of the study?

Social workers collect a lot of information about you as a client as part of the assessment process. For instance, a social worker would be required to assess you if you were referred by a hospital consultant, GP or district nurse for some home support, specialist equipment or a care package.

You would be asked a variety of questions such as; describe how well you are able to prepare and cook food; how well you are able to wash and dress, or mobility issues such as how well you are able to transfer from a seating to a standing position. This information helps you to receive the help and care that you need.

The University of Dundee wants to find out how this information is collected and what happens to it afterwards. We are interested in how social workers do this and so we would like to observe them while they actually carry out these tasks. Observing a real-life situation helps to provide a detailed picture of how this information is gathered and how it is used.

Do I have to take part?

You do not have to be involved if you do not wish. Your presence is purely voluntary and you can agree, refuse, or change your mind without any explanation, although we do hope you will be able to help with this worthwhile project. We will ask you to sign to say you have given your permission for the researcher to be present at your meeting. If you do not agree, it is not a problem, the researcher will not attend.

What would my presence involve?

You will not be asked to do anything, rather we would like to you continue as normal as possible since the study will focus on observing the social worker and not you as a client.

You may however wish to share your views or experiences about information that is collected about you. You are very welcome to do this. The researcher will take notes of your experiences and may use the information you give in the study report. We will of course ask your permission first.

What are the possible benefits of taking part?

There are no direct benefits of taking part in the study. However, we would hope that the information gathered will help us to understand how information is collected about you and how it is used. Such information is very important in providing you with the help you need as quickly as possible.

What are the possible risks of taking part?

There are no risks associated with this study.

What will happen to any information that I provide?

Any information that you provide will not be used in the study report without your permission. The information you give will be anonymised. That means that your personal details will not be used and you will not be recognised by anyone who reads the report.

What if I have a complaint?

In the unlikely event that you are unhappy with any aspect of the study process, you are advised the following:

If you believe that you have been harmed in anyway by taking part in this study, you have the right to pursue a complaint and seek any resulting compensation through Tayside Medical Science Centre (TASC) who are acting as the research sponsor. Details about this are available from the research team.

If you are a patient of NHS, you have the right to pursue a complaint through the usual NHS process. To do so, you can submit a written complaint to [redacted] *Please note that the NHS has no legal liability for non-negligent harm. However, if you are harmed and this is due to someone's negligence, you may have grounds for a legal action against* [redacted] *but you may have to pay your legal costs.*

What do I need to do now?

You do not have to do anything at the moment. The social worker will notify us if you are agreeable to the researcher being present. If you do not agree, the researcher will not attend.

Who has reviewed this study?

The East of Scotland Research Ethics Committee (REC2) has responsibility for scrutinising all proposals for medical research on humans in [redacted] They have examined the proposals and have raised no objections from the point of view of medical ethics. It is a requirement that records in this study be made available for scrutiny by monitors from Tayside Medical Science Centre (TASC) whose role is to check that research is properly conducted and the interests of those taking part are adequately protected.

For further information please contact the principal investigator:

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Appendices 3a, 3b, 3c: Participant Consent Forms

Study Title: Exploring contexts, processes and implications of social care data creation, coding and linkage - an ethnographic study.

Consent Form (Interview)

Please Initial Box

Name of Researcher: Anne Canny

1. I confirm that I have read and understood Participant Information Sheet (Interview) version 1.1., dated, 19th August, 2015 and I have had the opportunity to ask further questions. ☐

2. I understand that my participation is purely voluntary and that I am free to decline or withdraw at any time without explanation. ☐

3. I understand that my anonymised data may be looked at by individuals from [redacted] where it is relevant. ☐

4. I understand that data collected about me in this study may be used anonymously to support other research in the future, and may be shared with other researchers. ☐

Name	**Signature**	**Date**

Name of Person Taking Consent	**Signature**	**Date**

Participant Identification Number ☐

Appendix 3b, Participant Consent Form (Observation)

Study Title: Exploring contexts, processes and implications of social care data creation, coding and linkage - an ethnographic study.

Consent Form (Observation)

Please Initial Box

Name of Researcher: Anne Canny

5. I confirm that I have read and understood Participant Information Sheet (observation) version 1.1., dated, 19th August, 2015 and I have had the opportunity to ask further questions. ☐

6. I understand that my participation is purely voluntary and that I am free to decline or withdraw at any time without explanation. ☐

7. I understand that my anonymised data may be looked at by individuals from the [redacted] where it is relevant. ☐

8. I understand that data collected about me in this study may be used to support other research in the future, and may be shared anonymously with other researchers. ☐

Name	**Signature**	**Date**
Name of Person Taking Consent	**Signature**	**Date**

Participant Identification Number: ☐

Appendix 3c, Participant Consent Form (client/family members)

Study Title: Understanding Social Care Information Collection Processes.

Consent Form (Clients/Family Members)

Please Initial Box

Name of Researcher: Anne Canny

9. I confirm that I have read and understood client/family member Information Sheet version 1.1., dated, 19th August, 2015 and I have had the opportunity to ask further questions. ☐

10. I understand that my participation is purely voluntary and that I am free to decline or withdraw at any time without explanation. ☐

11. I understand that my anonymised data may be looked at by individuals from the [redacted] where it is relevant. ☐

12. I understand that data collected about me in this study may be used anonymously to support other research in the future, and may be shared with other researchers. ☐

Name	Signature	Date

Name of Person Taking Consent	Signature	Date

Participant Identification Number. ☐

Appendix 4: Study Topic Guide

Study Title: Exploring contexts, processes and implications of social care data creating, coding and linkage – an ethnographic study.

Study Topic Guide

15/05/15 V.1.0.

1. 1. What is your current role within your organisation?

2. 2. Who do you work for and most closely with? What is their role in relation to your work?

3. 3. Have you been involved with Health and Social Care data linking? (For instance, have you worked with data sets that have been combined from different services?)
    a. If so, tell me about it.
    b. If not, tell me what your views are.
    c. Tell me how this has developed in your department/region.

4. 4. Have you been involved with routinely collected social care data use in the past – whether collecting, recording, coding or linking?
    a. If so, tell me about it.
    b. How do you think routinely collected social care data has evolved or changed over time?
    c. What are your views regarding this?
    d. If you have not been involved with routinely collected social care data, tell me what your views are.

5. 5. Are you involved with routinely collected social care data use in your present role?
    a. (a). If so, tell me where you have experienced success.
        i. How was this success achieved?
        ii. Have your successes been shared with other departments/regions?
        iii. How have staff responded?

    b. (b) Tell me where you have had particular difficulties.
        i. Have these been overcome and how?
        ii. How have staff responded?

iii. If these have not been overcome, what do you recommend?
iv. Have you shared your difficulties with your supervisors/managers?
v. Have you shared your difficulties with other departments/regions?

6. 6. Can you tell me what impact your experiences have had – locally/regionally/nationally?
    a. Do you believe we need to collect other information that is not already collected and why?
    b. Do you believe there is information collected that is not useful and why?

7. 7. Can you tell me if performance is being monitored in relation to social care information collection, recording, coding or linking practices in your department?
    a. If so tell me about it.
    b. If not, tell me what your views are.

If you feel you require further information or clarification please do not hesitate to contact the principal investigator on the telephone number or email listed below.

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Appendix 5: Assessment of Services Summary Details Form

Please Tick: New Assessment [ ] Amendment to Existing Assessment [ ] Primary Referral No: Tagged Referral No: Assessment No:

SERVICE USER NAME : ..... URN: .....

Is the service user a 'new client' ? Yes [ ] No [ ]
(i.e. not currently receiving any services, excluding 'Advice and Support').

SWD WORKER:
Name Role Status

1st Contact Date
(*ie date of receipt of referral/service request leading to this assessment).* .....

Assessment start date: .....

Confirmation of needs date: .....

Assessment end date: .....

Date of Care and Support Plan .....

Cancellation date: .....

Closure date: .....

Single - Duty [ ]
Shared - Duty [ ]
Review [ ]
OT - Single [ ]
OT – Shared [ ]
Single - Simple [ ]
Single - Comprehensive [ ]
Single - Complex [ ]

MHO – Private Welfare Guardianship Asst [ ]
MHO - CSWO Guardianship Assessment [ ]
MHO - Emergency Detention Certificate Assessment - consent given [ ]
MHO - Emergency Detention Certificate Assessment - consent not given [ ]
MHO - Short Term Detention Assessment [ ]
MHO - Compulsory Treatment [ ]
MHO - Compulsion Order [ ]
MHO - Compulsion Order with Restriction Order [ ]
MHO – Social Circumstances Report [ ]

Shared - Simple [ ]
Shared - Comprehensive [ ]
Shared - Complex [ ]

Day Care - Single [ ]
Day Care - Shared [ ]

Carers [ ]

Add Support for Learning [ ]
Duty [ ]

Service Request [ ] (No additional assessment information required)

Has a carer's assessment been offered Yes [ ] No [ ] Date: If not, why not:

If yes, was it : Accepted [ ] Declined [ ] Date .....

Has a carer's assessment been offered Yes [ ] No [ ] Date: If not, why not:

If yes, was it : Accepted [ ] Declined [ ] Date .....

OVERALL ELIGIBILITY CATEGORY:

CRITICAL ☐ SUBSTANTIAL ☐ MODERATE ☐

LOW RISK ☐ NO RISK ☐ DATE CONFIRMED .....

SERVICE USER OPTION

OPTION 1 (Assessment) ☐ (Direct Payment)

OPTION 2 (Assessment) ☐ (Directing the available support)

OPTION 3 (Assessment) ☐ (Service arranged by LA)

OPTION 4 (Assessment) ☐ (A mixture of Options 1, 2 & 3)

OPTION - NO SERVICE PROVIDED ☐